

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

8364

08273

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cottage City</b>				c. LENGTH OF STAY IN 1b <b>44</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4107 Shepherd St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>Adams</b>				4. DATE OF DEATH Month <b>7</b> Day <b>7</b> Year <b>1960</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/12/1861</b>		9. AGE (In years last birthday) <b>99</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Matthew Buchanan</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Depue</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Gladys A. Tyrea-4107 Shepherd St. N.W.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic heart disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>10</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <b>3/5/1915</b> to <b>7/7/60</b> , 19____, that (I) (we) last saw the deceased alive on <b>7/7/60</b> , 19____, and that death occurred at <b>3:30 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>George J. Hager</b>				22b. DATE SIGNED _____		22c. PHYSICIAN'S NAME (Type) <b>George J. Hager</b>	
22d. ADDRESS <b>3717-38th Ave Cottage City Md</b>				22e. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/9/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Prince George Co. Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co. - Washington, D. C.</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 8 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

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8306

## CERTIFICATE OF DEATH

Reg. Dist. No.

18274

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>48 Mt. Rainier</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3308 Buchanan St. apt 201</u>		d. STREET ADDRESS <u>3308 Buchanan apt. 201</u>	
3. NAME OF DECEASED (Type or print) First <u>Camille</u> Middle <u>—</u> Last <u>Albers</u>		4. DATE OF DEATH Month <u>7</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/13/1890</u>
9. AGE (In years lost birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper, Nassau Hospital, N.Y.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Brooklyn, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter</u>		14. MOTHER'S MAIDEN NAME <u>Wilhelmina Anderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>124-12-8645</u>	
17. INFORMANT <u>Edwin C. Albers, son</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, breast, with metastases</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>15 July 1960</u> to <u>29 July 1960</u> , that I lost sowing the deceased olive on <u>15 July 1960</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jules Gilbert</u>		ADDRESS (Street, city or town, state) <u>3200 Chillum Rd. Mt. Rainier</u>	
PHYSICIAN'S NAME (Type) <u>Jules Gilbert, M.D.</u>		DATE SIGNED <u>3200 Chillum Rd. Mt. Rainier, Md.</u>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>—</u>	22b. DATE THEREOF <u>8/1/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>		ADDRESS <u>Mt. Rainier, Md.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Knead</u>	

CERTIFICATE OF DEATH

2306

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Place of birth: [illegible]  
6. Date of death: [illegible]  
7. Place of death: [illegible]  
8. Cause of death: [illegible]  
9. Signature of physician: [illegible]  
10. Signature of registrar: [illegible]  
11. Date of registration: [illegible]



8377

## CERTIFICATE OF DEATH

Reg. Dist. No.

08275

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Geo. Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>West Hyattsville</b>				c. LENGTH OF STAY IN 1b <b>unknown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>630 Sheridan Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Harvey Lee Anderson</b>				4. DATE OF DEATH Month Day Year <b>July 22 1960</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/9/1898</b>		9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Policeman Metropolitan Police</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas L. Anderson</b>				14. MOTHER'S MAIDEN NAME <b>-- Vaughn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>578-42-4612</b>			
17. INFORMANT <b>Irene Anderson</b>				Address <b>W. Hyattsville Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarct</b> DUE TO <b>Coronary Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>14 yrs.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 20, 1960</b> to <b>July 22, 1960</b> , that I last saw the deceased alive on <b>July 22, 1960</b> , and that death occurred at <b>11 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Thomas J. Kelly</b>				ADDRESS (Street, city or town, state) <b>6480 N. H. Ave. Takoma Park, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Thomas J. Kelly, M. D.</b>				DATE SIGNED <b>7/22/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>7/25/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Washington, D. C.</b>				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co.</b>				ADDRESS <b>Washington, D. C.</b>		24a. REC'D BY REGISTRAR <b>Arthur S. Hines</b>	
				DATE <b>JUL 25 '60</b>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8370

## CERTIFICATE OF DEATH

Reg. Dist. No.

08276

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION E. Leland Memorial Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lucy Dolly Arnold		4. DATE OF DEATH July 30 19 60	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/30/77
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Stanley Pickrell		14. MOTHER'S MAIDEN NAME Molly or Mary Pickrell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Record -		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x DUE TO Night Hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Thrombosis (c) DUE TO General arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 26, 1960, to July 30, 1960, that I last saw the deceased alive on July 29, 1960, and that death occurred at 5:30 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE L W Malin		ADDRESS (Street, city or town, state) Riverdale, Md 730-60	
PHYSICIAN'S NAME (Type) L W Malin MD		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-2-60	
22c. NAME OF CEMETERY OR CREMATORY Christ Ch. Cem.		22d. LOCATION (City, town, or county) (State) Accokeek Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md		24a. REC'D BY REGISTRAR DATE AUG 4 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8308

CERTIFICATE OF DEATH

108277

Item 1 Film 266 8-2-60 et

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLEY</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George's Gen. Hospital</u>		d. STREET ADDRESS <u>6309 CARSON AVE.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>H.</u> Last <u>BALDERSON</u>		4. DATE OF DEATH Month <u>7</u> Day <u>24</u> Year <u>60</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-6-1908</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sea Food Clerk</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles B Balderson</u>		14. MOTHER'S MAIDEN NAME <u>Sophie E Watson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Thelma Balderson</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mths.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/23</u> 19 <u>60</u> to <u>7/24</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>7/24</u> 19 <u>60</u> , and that death occurred at <u>9:15</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Norman Donat Cureau</u> M.D.		22b. DATE SIGNED <u>7/24/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Norman Donat Cureau</u>		22d. ADDRESS <u>3513 Bay St. Mt Rainier Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>7-27-1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>		23d. LOCATION (City, town, or county) (State) <u>Wash D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Mattingly</u>		25a. REC'D BY REGISTRAR <u>  </u> DATE <u>JUL 27 60</u>	
ADDRESS <u>Wash D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Frank</u>	



CERTIFICATE OF DEATH

8308

(M)

(1)





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE BOARD OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 23c & d, Film 6267 7/15/60 iwk

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b> c. LENGTH OF STAY IN 1b <b>5 months &amp; 28 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenn Dale Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>-</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>1701 Swann St., N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Horace</b> Middle <b>-</b> Last <b>Beasley</b>		4. DATE OF DEATH Month <b>7</b> Day <b>5</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/15/15</b>
9. AGE (In years lost birthday) <b>44</b> yrs.		10. IF UNDER 1 YEAR Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b>	11. IF UNDER 24 HRS. Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jesse Beasley</b>		14. MOTHER'S MAIDEN NAME <b>Mary Tolliver</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-12-8656</b>	
17. INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Aortic insufficiency</b> DUE TO <b>Acute staphylococcal bacterial endocarditis</b> (c) <b>(healed)</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic pyelonephritis</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/7/1960</b> to <b>7/5/1960</b> , that (I) (we) last saw the deceased alive on <b>7/5/1960</b> , and that death occurred at <b>5:15 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Moe Weiss</b>		22b. DATE SIGNED <b>7/5/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>7/5/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Natl. Memorial Harmony Pk. Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Montgomery Bros.</b>		25a. REC'D BY REGISTRAR <b>Jul 8 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Carlton S. Kraus</b>			

3882

CERTIFICATE OF DEATH

Washington

St. Louis

(Date of Death)

1917

1917

Age

Sex

Color

Marital

Occupation

Place of Birth

Residence

Place of Death

Place of Burial

Signature

Signature

Signature

Signature

Signature

Signature

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Signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08279

8379

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>West Hyattsville</i>		c. LENGTH OF STAY IN 1b <i>3 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>West Hyattsville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>6611 24th Place</i>				d. STREET ADDRESS <i>16611 24th Place</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Benjamin</i> Middle <i>Franklin</i> Last <i>Becraft</i>				4. DATE OF DEATH Month <i>July</i> Day <i>21</i> Year <i>1960</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 27 1875</i>	9. AGE (In years last birthday) <i>84</i> yrs.	IF UNDER 1 YEAR Months <i>8</i> Days <i>21</i> Hours <i>19</i> Min.	IF UNDER 24 HRS. Hours <i>19</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer Market</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Same</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Mr. James Becraft</i>				14. MOTHER'S MAIDEN NAME <i>Mary Golden</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <i>Mrs. Mary Becraft (Wife)</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Prostate</i> <i>177X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>177X</i> DUE TO (c) <i>Senility</i>						INTERVAL BETWEEN ONSET AND DEATH <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senility</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <i>o. 11</i> p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb 12, 1950</i> to <i>July 21, 1960</i> that I last saw the deceased alive on <i>July 20, 1960</i> , and that death occurred at <i>4:30 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Philip E. Jones</i> M.D.				ADDRESS (Street, city or town, state) <i>918 Ellsworth Drive Silver Spring Md</i>			
PHYSICIAN'S NAME (Type) <i>Philip E. Jones</i>				DATE SIGNED <i>7/21/60</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 24, 1960</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Union Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Bethesda Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>DeWitt Davidson, Laurel Md</i>				24a. REC'D BY REGISTRAR DATE <i>JUL 26 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	



1  
 8309  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH  
 08280

1. PLACE OF DEATH o. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>3 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Ellen</b> First Middle Last				4. DATE OF DEATH <b>July 28 1960</b> Month Day Year			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 9 16, 1930</b>	
9. AGE (In years last birthday) <b>29</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>			
11. BIRTHPLACE (State or foreign country) <b>Florida</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>George E Jackson</b>				14. MOTHER'S MAIDEN NAME <b>Prudence E. Criss</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>578-40-3596</b>			
17. INFORMANT <b>Aurelio Biado</b>				18. MOTHER'S MAIDEN NAME <b>Mt Rainier Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the</b> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Adeno ca in the r h breast</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1948</b> to <b>July 28 1960</b> , that (I) (we) last saw the deceased alive on <b>19 60</b> , and that death occurred at <b>10:30 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Benjamin S. Miller</b> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Benjamin S. Miller, M.D.</b>				22d. ADDRESS <b>3824 31st St. Mt Rainier, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/1/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl.</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Chambers Codac</b> ADDRESS <b>Riversdale Md</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 3 '60</b>			
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



CERTIFICATE OF GRADE

8110

Virginia, Prince George

Prince George

W. H. Hatcher

3 days

Overnight

Prince George General Hospital

W. H. Hatcher

Blade

Blade

Sept. 10, 1930

Blade

At Home

Honorable

Virginia

U.S.A.

Frederick E. Giles

George E. Jackson

2nd St. N.E.

Blade

Blade

*Handwritten signature and text, mostly illegible.*

Arlington, Va.

Arlington Hall

8/1/30

Blade



8296

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

118281

Items 8, 9 Film 6257 7-29-60 et

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> c. LENGTH OF STAY IN 1b <b>52</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>817 S heridan St</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>817 S heridan St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>George H Birch</b>		4. DATE OF DEATH Month Day Year <b>July 5 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1890</b> <b>Jan. 10 1888</b>
9. AGE (In years lost birthday) <b>70 72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>70 72</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard I. Birch</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Danner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>F. L. Walker (Nephew)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INANITION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA LARGE BOWEL WITH METASTASES</b> DUE TO (c) <b>2 YEARS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3 MONTHS</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5 JULY 1960</b> to <b>5 JULY 1960</b> , that (I) (we) last saw the deceased alive on <b>NEVER</b> , and that death occurred at <b>4:45</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Henry R. Wolfe</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>HENRY R. WOLFE M.D.</b>		22d. ADDRESS <b>905 SHERIDAN ST. HYATTSTVILLE, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/7/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION (City, town, or county) (State) <b>S uitland Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home - Washington D.C.</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 7 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CORONER MALONEY NOTIFIED. HE APPROVES RELEASE. H.W. WOLFE, M.D.

1950

(M)

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH

1950

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

CAUSE OF DEATH

IMMEDIATE

UNDERLYING

INTERVIEW

DATE OF INTERVIEW

PLACE

(1)

MASSACHUSETTS DEPARTMENT OF HEALTH

RECORDS SECTION

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an affidavit is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

(M)

09

1

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8311 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 118283											
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>30 Cedar Heights</u>					
c. LENGTH OF STAY IN 1b <u>Dead on arrival</u>						d. STREET ADDRESS <u>1017-65th Warner</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>James Frank Black</u>						4. DATE OF DEATH <u>July 29 1960</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 27, 1927</u>		9. AGE (In years last birthday) <u>32</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Unemployed</u>					
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Henry Black</u>						14. MOTHER'S MAIDEN NAME <u>Irene Watkins</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <u>Yes</u> <u>WWII</u>						16. SOCIAL SECURITY NO. <u>—</u>					
17. INFORMANT <u>Curtis Black, 321 East Biddle St, Baltimore, Md</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis</u> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>James I. Bay</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>James I. Bay</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify)						22b. DATE THEREOF <u>8-3-60</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat Cemetery Va</u>						22d. LOCATION (City, town, or country) (State) <u>7-30-60</u>					
23. FUNERAL DIRECTOR <u>Henry S. Washington</u>						24a. REC'D BY REGISTRAR <u>AUG 3 '60</u>					
ADDRESS <u>4925 Dean Ave NE</u>						24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>					



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME  
SM 7/59

1  
FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8310

08282

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn Hyattsville, Maryland</b> d. STREET ADDRESS <b>4703 - 68th. Ave.</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Maryland</b> c. LENGTH OF STAY IN lb <b>D.O.A.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's Gen. Hospital</b>					
3. NAME OF DECEASED (Type or print) <b>William Jefferson Blalock</b>			4. DATE OF DEATH <b>July 6 1960</b>		
5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>Oct. 15, 1919</b> 9. AGE (In years last birthday) <b>40</b> yrs.			IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Mechanic</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>North Carolina</b>		
11. BIRTHPLACE (State or foreign country) <b>USA</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>William J. Blalock</b>			14. MOTHER'S MAIDEN NAME <b>Sarah C. Fields</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> <b>World War 2</b> 16. SOCIAL SECURITY NO. <b>577-10-6708</b> 17. INFORMANT <b>Wife</b> Address <b>Mrs. Virginia L. Blalock</b>			Same as #2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X</b> DUE TO <b>Acute congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Cardiovascular renal disease</b> (c)			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John T. Maloney</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 7-7-1960 DATE SIGNED			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 2202 Cheverly Ave. Cheverly, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-11-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem</b>	
				22d. LOCATION (City, town, or country) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR <b>W.W. Chambers Co Riverdale Md</b>		24a. REC'D BY REGISTRAR <b>Arthur S. House</b>			
		24b. REGISTRAR'S SIGNATURE			



John P. Anderson

2205 Chevrolet  
Chevrolet, N.Y.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dis./No. 8284

8380

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u> c. LENGTH OF STAY IN 1b <u>1 yr., 3 mos. and 28 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Glenn Dale Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>-</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>1012 Mass. Ave., N. W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Jessie</u> Middle <u>E.</u> Last <u>Boyer</u>				<b>4. DATE OF DEATH</b> Month <u>7</u> Day <u>18</u> Year <u>1960</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>10/7/03</u>		<b>9. AGE</b> (In years last birthday) <u>56</u> yrs. <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Waitress</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Ark.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>John McClouch</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Amanda Thompson</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>-</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>		<b>17. INFORMANT</b> <u>Decedent</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Operative death (cardiac arrest)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemorrhage from left pulmonary artery</u> DUE TO (c) <u>-</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> a. m. <u>-</u> p. m.	
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>	
<b>ACTUAL SIGNATURE</b> <u>John T. Maloney</u> <b>M.D.</b> <b>EXAMINER'S NAME (Type)</b> <u>John T. Maloney, M.D.</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, or other disposal (Specify)</b> <u>7/22/60</u>		<b>22b. DATE THEREOF</b> <u>7/22/60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Wash. Natl. Cemetery</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Sanitland Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. W. Chambers Co.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>DATE JUL 21 '60</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse. If certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



8312

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George County</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>5 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Delia</b> Middle <b>L</b> Last <b>Breece</b>				4. DATE OF DEATH Month <b>July</b> Day <b>31</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-10-93</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>N. CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ROBERT MORGAN</b>				14. MOTHER'S MAIDEN NAME <b>COPE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Early Bronch pneumonia</b> DUE TO <b>Pul. Cong. &amp; edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arterio Sclerotic Ht de.</b> (b) <b>Parkinsonism</b> (c) <b>Arterio Sclerotic Ht de.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 Days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Parkinsonism</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1954</b> , 19____, to <b>7/31/60</b> , 19____, that I last saw the deceased alive on <b>7/30/60</b> , 19____, and that death occurred at <b>2:20P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Gordon W. Kelly</b>				ADDRESS (Street, city or town, state) <b>6124 41st Ave., Hyattsville, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Gordon Kelly, M.D.</b>				DATE SIGNED <b>8/1/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug 3, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>H. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bladensburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>CHAMBERS FUNERAL HOME</b>				ADDRESS <b>RIVERDALE, MD</b>		24a. REC'D BY REGISTRAR <b>AUG 4 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbox papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8312

Winston-Salem, N.C.

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Winston-Salem, N.C.

8381

CERTIFICATE OF DEATH

Reg. Dist. No.

08286

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WASH., D.C.</b> b. COUNTY <b>47X3</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>AVONDALE</b>				c. LENGTH OF STAY IN 1b <b>2 yrs +</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CARROLL MANOR</b>				d. STREET ADDRESS <b>2520-10th St. N.E.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARIE T. BREWER</b>				4. DATE OF DEATH Month Day Year <b>JULY 24, 1960</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB. 19, 1883</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESLADY - RETIRED</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>RIZIK'S</b>		11. BIRTHPLACE (State or foreign country) <b>LEONARDTOWN, MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>GEORGE R. BREWER</b>				14. MOTHER'S MAIDEN NAME <b>JULIA WATHEN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>			
17. INFORMANT Address <b>MARGARET DORSEY-2520-10th St., N.E.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic stasis of pulmonary circulation</b> DUE TO (c) <b>Severe osteomyelitis generalis Arthritis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <b>Dry gangrene - especially left leg - Abscess right</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>Weeks</b> <b>Years</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Nov</b> , 19 <b>59</b> , to <b>July</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>July 21</b> , 19 <b>60</b> , and that death occurred at <b>7:45 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Richard P. DeLong</b> M.D.				ADDRESS (Street, city or town, state) <b>4323 Harvard St Silver Spring, Md</b>			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/27/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JAMES T. RYAN, INC. J. Ryan</b> ADDRESS <b>317 PA. AVE SE WASH., D.C.</b>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>	
DATE <b>JUL 26 '60</b>							







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1

8313

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08287

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <del>GEN</del> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ernest C Browne</b>		4. DATE OF DEATH <b>July 17 19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 Dec. 1885</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>Govt Bureau of Census</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Govt Bureau of Census</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Edward S Browne</b>		14. MOTHER'S MAIDEN NAME <b>Victoria Bean</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Anna Mae Browne</b>		Address <b>Mt Rainier, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>massive antero-septal infarction</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive arteriosclerotic heart disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>7-14-60</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7-14</b> to <b>7-17</b> , that (I) (we) last saw the deceased alive on <b>7-17</b> , and that death occurred on <b>7-17</b> from the causes and on the date stated above.		22a. SIGNATURE <b>George Hageage</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>7-17-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. George Hageage, M.D.</b>		22d. ADDRESS <b>3717-38th Ave College City Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 19, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Md.</b>	
25a. REC'D BY REGISTRAR <b>JUL 19 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

8313

OFFICE OF BATH

0285

Handwritten notes and stamps, including "OFFICE OF BATH" and "8313".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

8382

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08288

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Glenn Dale		c. LENGTH OF STAY IN 1b 19 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last RENA - BRYANT		4. DATE OF DEATH Month Day Year July 9 1960	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1877
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Richmond, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME G. W. Watkins		14. MOTHER'S MAIDEN NAME Serena Ann Acree	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unk	
17. INFORMANT Person		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis, Far Advanced, Active DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 13 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia, bilateral; Cor Pulmonale; Chronic pyelonephritis; Coronary insufficiency		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Dec. 3 1958, to July 9 1960, that (X) (we) last saw the deceased alive on July 9 1960, and that death occurred at 1:00 AM, from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED July 9, 1960	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS 1006 Glenn Dale Hospital, Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 7-9-60		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. - N. W. Washington		25a. REC'D BY REGISTRAR DATE JUL 14 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			



# 1 FOR STATE HEALTH DEPT.

TO DO CITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8314 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08289											
1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>13 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Oxen Hill</b> d. STREET ADDRESS <b>Livingston Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>William</b>			First <b>William</b>		Middle <b>BUTLER</b>		Last <b>BUTLER</b>		4. DATE OF DEATH Month <b>July</b> Day <b>2</b> Year <b>1960</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct 7, 1883</b>		9. AGE (In years last birthday) <b>76</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert Butler</b>					14. MOTHER'S MAIDEN NAME <b>Alice Sweetney</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>James Butler (Bro) 380 st NW, Wash., DC</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxemia and exhaustion</b> DUE TO <b>916.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Third degree burns of the body and extremities</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Occupant of a house that burned</b>							
20c. TIME OF INJURY Month, Day, Year <b>8 40 JUNE 18, 1960</b> Hour a.m. <b>8</b> p.m. <b>40</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HOME</b>		20f. (City or town) <b>5321 LIVINGSTON RD OXEN HILL</b>		(County) <b>P.R.G.</b> (State) <b>MARYLAND</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>James I. Boyd</b>					CHIEF MEDICAL EXAMINER			DATE SIGNED <b>July 2, 1960</b>			
EXAMINER'S NAME (Type) <b>James I. Boyd</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>July-7-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Ignatius Catholic Church Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Oxen Hill, Maryland</b>		
23. FUNERAL DIRECTOR <b>John T. Rhines &amp; Company</b>					ADDRESS <b>3015 12th St., N.E.</b>		24a. REC'D BY REGISTRAR <b>JUL 6 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

MEDICAL CERTIFICATION



MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
 STATE OF MARYLAND  
 COUNTY OF PRINCE GEORGE

I, the undersigned, being a duly qualified Medical Examiner of the County of Prince George, State of Maryland, do hereby certify that on the 13th day of July, 1900, at the residence of the deceased, I examined the body of  
 Name of Deceased: **James Butler**  
 Age: **38**  
 Sex: **Male**  
 Color: **Colored**  
 Occupation: **Carpenter**  
 Residence: **Prince George General Hospital**  
 Cause of Death: **Toxemia and exhaustion**  
 Date of Death: **July 2, 1900**  
 Place of Death: **at his home, No. 38 U at St. Ann., DC**  
 Signature of Medical Examiner: **James Butler**  
 Date of Certificate: **July 2, 1900**



This is to certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Medical Examiner of the County of Prince George, State of Maryland, on the 2nd day of July, 1900.  
 Notary Public for Prince George County, Maryland.  
 Date: **July 2, 1900**

may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
8315

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08290

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b: <b>4 da.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				d. STREET ADDRESS <b>40001 38th St.</b>			
3. NAME OF DECEASED (Type or print) First <b>Irene</b> Middle <b>Callow</b> Last <b>Callow</b>				4. DATE OF DEATH Month <b>July</b> Day <b>3</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-2-86</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>4</b>		IF UNDER 24 HRS. Hours <b>4</b> Min. <b>5</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>George Hammer</b>				14. MOTHER'S MAIDEN NAME <b>Emma Saur</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Hospital Records</b> Address <b>Cheverly, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>OVERWHELMING TOXEMIA</b> DUE TO (b) <b>INTESTINAL OBSTRUCTION</b> DUE TO (c) <b>ISCANTERATED ABDOMINAL HERNIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1959</b> to <b>July 3 1960</b> , that (I) (we) last saw the deceased alive on <b>July 3 1960</b> and that death occurred at <b>5:45pm</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Norman V. ...</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Dr. N. Comeau M.D.</b>				22d. ADDRESS <b>3503 Perry Street, Mt. Rainier, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 6, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR <b>JUL 7 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. ...</b>	

RECEIVED  
JAN 17 1964  
U.S. DEPARTMENT OF HEALTH  
CENTERS FOR DISEASE CONTROL  
DIVISION OF FIELD SERVICES  
BRANCH OF COMMUNITY AND PREVENTIVE SERVICES  
WASHINGTON, D.C. 20540  
TO: DIRECTOR, DIVISION OF FIELD SERVICES  
FROM: SAC, NEW YORK (100-100000)  
SUBJECT: [Illegible]  
RE: [Illegible]  
[Illegible text follows, mostly mirrored bleed-through from the reverse side of the page.]



TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an relay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

1  
FOR STATE  
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
8316 08291											
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>D. C.</b> b. <del>X</del> <b>XXXX</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>1617 H Street, S. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Donald</b> Middle <b>Robert</b> Last <b>Cameron</b>					4. DATE OF DEATH Month <b>July</b> Day <b>16</b> Year <b>60</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 7, 1904</b>		9. AGE (In years by birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months <b>19</b> Days <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brick Layer</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>New York</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William J. Cameron</b>					14. MOTHER'S MAIDEN NAME <b>Flossie Lints</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>111-09-8941</b>		17. INFORMANT <b>Mrs. Carl J. Reisinger</b> Address <b>220 Abbotts Road Schenectady, N.Y.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>Cardiovascular Renal Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) DATE SIGNED <b>July 16, 1960</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>7/19/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frankfort</b>		22d. LOCATION (City, town, or country) (State) <b>Frankfort, N.Y.</b>				
23. FUNERAL DIRECTOR <b>W. W. Chambers Co. Riverdale, Md.</b>						24a. REC'D BY REGISTRAR DATE <b>JUL 19 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

XXX

5. D. C.

George George

not valid.

2004

Approved

Prison George's General Hospital, 1017 N Street, S. E., Wash. D. C.

0013182

Report

## Discussion

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2004 7 20

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49721-2017

DOMESTIC & FOREIGN

REF ID: A63055

550 Abbott Road  
Baltimore, Md. 21206

226-155

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James I. Boyd, M.D.

*E. J. Connelley*

Environ



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 8317  
 Item 9 8316209 8-19-60 et

**CERTIFICATE OF DEATH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

08292

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>8 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47 Mt. Rainier</b>	
		d. STREET ADDRESS <b>1 3509 37th St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Leolie</b> Middle <b>E.</b> Last <b>Casto</b>		4. DATE OF DEATH 23 July 1960 19	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>
9. AGE (In years lost birthday) <b>97 99</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>in own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown Casto</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Zelma Miller</b> Address <b>(Same as above)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Mnesia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardio Vascular Disease 5 years</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7/15</b> 19 <b>60</b> to <b>7/23</b> 19 <b>60</b> , that (I) (we) lost the deceased <b>olive</b> on <b>7/23</b> 19 <b>60</b> and that death occurred <b>at 2:10 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Norman Donatimeau</b> M.D.		22b. DATE SIGNED <b>7/24/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Norman Donatimeau</b>		22d. ADDRESS <b>3503 Penn W. Mt Rainier Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/26/1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Siniaville Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Statts Mill, W. Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Valley's Funeral Home</b> ADDRESS <b>3200-R.I. Ave. Mt. Rainier Md</b>		25a. REC'D BY REGISTRAR <b>JUL 27 '60</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

CERTIFICATE OF DEATH

1917



State of Ohio

County of Hamilton

City of Cincinnati

Age 35

Sex Male

Color White

25

Unknown

Unknown

Unknown

U.S.A.

Ohio

In own home

Longevity

Unknown

Unknown

Unknown

(Name as above)

John Miller

John

No

1  
FOR STATE  
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. (Pages 1, 2, and 3 may be retained for your files.) TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Items 8, 9 Film 267-7-29-60 at 08293											
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. LENGTH OF STAY IN TB <u>Deed named</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Prince Georges</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>18 Wilberest Heights</u>	
3. NAME OF DECEASED (Type or print) <u>Julia Columbia Ukesh Chalk</u>		4. DATE OF DEATH Month <u>July</u> Day <u>24</u> Year <u>1960</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month <u>August</u> Day <u>30</u> Year <u>1880</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gun Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.-C</u>		13. FATHER'S NAME <u>Frank Darbour</u>		14. MOTHER'S MAIDEN NAME <u>Mary Fore</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Helen Leith, same as #2</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> DUE TO (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u>442X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
21. ACTUAL SIGNATURE <u>James I. Boyd</u>		21. EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>		21. M.D. <u>James I. Boyd</u>		21. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		21. DATE SIGNED <u>July 24, 1960</u>		21. Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-27-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wm. &amp; Mary Episcopal Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Wayside (Chesley) Md.</u>		23. FUNERAL DIRECTOR <u>Simmons Bros.</u>		23. ADDRESS <u>1661-1600 Maple Rd SE Wash 20</u>	
24a. REC'D BY REGISTRAR <u>Jul 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Smith</u>		24c. REGISTRAR'S NAME <u>Arthur S. Smith</u>		24d. REGISTRAR'S ADDRESS <u>1661-1600 Maple Rd SE Wash 20</u>		24e. REGISTRAR'S PHONE <u>20</u>		24f. REGISTRAR'S CITY <u>Wash</u>	

1058

WATKINS STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER - CITY OF CHICAGO

2112

THE CITY OF CHICAGO  
DEPARTMENT OF HEALTH  
OFFICE OF THE MEDICAL EXAMINER

1

CHICAGO, ILL. 6-1-1900

6-1-1900

CHICAGO, ILL. 6-1-1900

6-1-1900

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

08294

8319

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN lb <b>6 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>1 4212 53rd Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>Morris</b> Middle <b>C</b> Last <b>Chaney</b>				4. DATE OF DEATH Month <b>10</b> Day <b>July</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>28 Oct. 1890</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>10</b> Hours <b>19</b> Min.		IF UNDER 24 HRS. Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired S Kanns Company</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Samuel Chaney</b>				14. MOTHER'S MAIDEN NAME <b>Medora Whittington</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Louise Chaney</b> Address <b>same as no 2.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> DUE TO <b>with terminal Bronchopneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>7 days</b> DUE TO (c) <b>7 days</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7-5</b> 19 <b>60</b> , to <b>7-10</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>7-9</b> 19 <b>60</b> , and that death occurred at <b>5:35 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Ronald S. Fleischer</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>RONALD S. FLEISCHER</b>				22d. ADDRESS <b>432 QUEEN'S CHAPEL RD HYATTSVILLE</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 13, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR <b>JUL 15 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Knapp</b>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

1111

1. Name of deceased: John J. Kennedy

2. Date of death: July 12, 1950

3. Place of death: St. Vincent's Hospital, New York, N.Y.

4. Age at death: 68

5. Sex: Male

6. Race: White

7. Marital status: Married

8. Occupation: Engineer

9. Cause of death: Heart disease

10. Signature of physician: Dr. J. J. Kennedy

11. Signature of registrar: John J. Kennedy

12. Signature of informant: John J. Kennedy

13. Signature of witness: John J. Kennedy

14. Signature of witness: John J. Kennedy

15. Signature of witness: John J. Kennedy

16. Signature of witness: John J. Kennedy

17. Signature of witness: John J. Kennedy

18. Signature of witness: John J. Kennedy

19. Signature of witness: John J. Kennedy

20. Signature of witness: John J. Kennedy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08295

8383

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Malboro</b>		c. LENGTH OF STAY IN 1b <b>Unk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF Hospital Andrews</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Deborah</b> Middle <b>Delene</b> Last <b>CHOSKE</b>		4. DATE OF DEATH Month <b>July</b> Day <b>4</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasion</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5 June 1960</b>
9. AGE (In years lost birthday) <b>0 yrs.</b>		10. IF UNDER 1 YEAR Months <b>—</b> Days <b>29</b>	11. IF UNDER 24 HRS. Hours <b>—</b> Min. <b>—</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (State or foreign country) <b>USAF Hospital Andrews</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Donald D. Choske</b>		14. MOTHER'S MAIDEN NAME <b>Denise A. Valliere</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>N/A</b>	
17. INFORMANT <b>Fred L. Witzgall, 1/Lt USAF AOD</b>		Address <b>USAF Hospital Andrews</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Unknown (Dead On Arrival)</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Unknown</b> (c) <b>Unknown</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>Jul 4 1960</b> p. m. <b>Jul 4 1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4 July</b> , 1960, to <b>4 July</b> , 1960, that I last saw the deceased alive on <b>Never Seen</b> , 19 <b>---</b> , and that death occurred at <b>Unk</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>WASHINGTON 25, D.C.</b> DATE SIGNED <b>4 JULY 60</b> ACTUAL SIGNATURE <b>Charles S. Moon</b> M.D. <b>USAF HOSPITAL ANDREWS</b> PHYSICIAN'S NAME (Type) <b>CHARLES S. MOON, Capt USAF MC</b> <b>WASHINGTON 25, D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/7/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James T. Ryan, Inc.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 7 '60</b>	
ADDRESS <b>317 Pa.Ave., SE DC3</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

2050202XV 5

CERTIFICATE OF DEATH

1911

Full name of deceased: \_\_\_\_\_

Age: \_\_\_\_\_

Residence: \_\_\_\_\_

Sex: \_\_\_\_\_

Married: \_\_\_\_\_

Occupation: \_\_\_\_\_

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

Registrar: \_\_\_\_\_

Union: \_\_\_\_\_

Full name of deceased: \_\_\_\_\_

Age: \_\_\_\_\_

Residence: \_\_\_\_\_

Sex: \_\_\_\_\_

Married: \_\_\_\_\_

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08296

Reg. Dist. No.

8320

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherryland</u> c. LENGTH OF STAY IN 1b <u>Dead on arrival</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hosp</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P.S.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Coxon Hill</u> d. STREET ADDRESS <u>11711 - Cowans Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Gilbert Irving Cox</u>		<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>13</u> Year <u>1960</u>		<b>5. SEX</b> <u>Male</u>			
<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>March 9, 1920</u>			
<b>9. AGE</b> (In years last birthday) <u>40</u> yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Plant Supt.</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Iron Smith Shop</u>			
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Joseph Kelly Cox</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Clise Owens</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>			
<b>17. INFORMANT</b> <u>Gilbert Irving Cox, Jr. Son</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO <u>gun shot wound of chest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>gun shot wound of chest</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>					
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with revolver</u>		<b>20c. TIME OF INJURY</b> Month, Day, Year <u>How</u> <u>even</u> <u>7-13</u> <u>1960</u> <u>p. m.</u>					
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		<b>20f. (City or town)</b> <u>Coxon Hill P.S. Md</u> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>James I. Boyd</u>		<b>EXAMINER'S NAME (Type)</b> <u>JAMES I. BOYD</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial July 16-60</u>		<b>22b. DATE THEREOF</b> <u>July 16-60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St Barnabas</u>			
<b>22d. LOCATION (City, town or county)</b> <u>Coxon Hill Md</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DATE JUL 18 '60</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Finns</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Simmons Brothers</u>							
<b>ADDRESS</b> <u>1661 - 9d Hope Rd &amp; E Wash oc</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.

VR A15 (4)  
15M 9/59

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8321

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

08297

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>3820 31 St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>U</b> Last <b>Dalton</b>		4. DATE OF DEATH Month <b>July</b> Day <b>3</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3 Sept. 1883</b>
9. AGE (In years lost birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bobbin Threader</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Alta Vista, Va. Sycamore, Va.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Louis Updike</b>		14. MOTHER'S MAIDEN NAME <b>Mary Bett White</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>577-12-2374</b>	
17. INFORMANT <b>Mrs. E. R. Beamy</b>		Address <b>3800-37th Place Hyattsville</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332X Cerebrovascular thrombosis</b> DUE TO (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>Generalized arteriosclerosis</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between onset and death</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 2 19 60</b> to <b>July 3 19 60</b> that (I) (we) lost the deceased alive on <b>July 3 19 60</b> , and that death occurred on <b>July 3 19 60</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>William D. Rosson</b>		22b. DATE SIGNED <b>7/3/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. W. Rosson M.D.</b>		22d. ADDRESS <b>5304 ANNAPOLIS RD BLADENSBURG, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/6/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		23d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Nellie's Funeral Home, Mt. Rainier, Md.</b>		25a. REC'D BY REGISTRAR <b>Arthur S. Kraus</b>	
ADDRESS <b>3200 R.I. Ave.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
DATE <b>JUL 7 '60</b>			

8851

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Place of birth: [illegible]  
6. Date of death: [illegible]  
7. Place of death: [illegible]  
8. Cause of death: [illegible]  
9. Signature of physician: [illegible]  
10. Signature of registrar: [illegible]

11. Name of informant: [illegible]  
12. Address of informant: [illegible]  
13. Signature of informant: [illegible]

14. Name of witness: [illegible]  
15. Address of witness: [illegible]  
16. Signature of witness: [illegible]

17. Name of witness: [illegible]  
18. Address of witness: [illegible]  
19. Signature of witness: [illegible]

20. Name of witness: [illegible]  
21. Address of witness: [illegible]  
22. Signature of witness: [illegible]

23. Name of witness: [illegible]  
24. Address of witness: [illegible]  
25. Signature of witness: [illegible]

26. Name of witness: [illegible]  
27. Address of witness: [illegible]  
28. Signature of witness: [illegible]

29. Name of witness: [illegible]  
30. Address of witness: [illegible]  
31. Signature of witness: [illegible]

32. Name of witness: [illegible]  
33. Address of witness: [illegible]  
34. Signature of witness: [illegible]

35. Name of witness: [illegible]  
36. Address of witness: [illegible]  
37. Signature of witness: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08298

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Meland Memorial Hosp.				d. STREET ADDRESS 15704 36 <sup>th</sup> Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BEN HARRISON				4. DATE OF DEATH July 30 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-14-88	
9. AGE (In years lost birthday) 71 yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Monotype Operator				10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME TIMOTHY DALY				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES W.W.I.				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Hospital Record Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Arteriosclerotic Heart Disease (c) DUE TO General Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 5 min 6 yrs 20 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from July 30, 1960, to July 30, 1960, that (I) (we) last saw the deceased alive on July 30, 1960, and that death occurred at 7:31 P.M. from the causes and on the date stated above.							
22a. SIGNATURE L.W. Malin				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-31-60	
22c. PHYSICIAN'S NAME (Type) L.W. Malin M.D.				22d. ADDRESS Riverdale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/3/60		23c. NAME OF CEMETERY OR CREMATORY Arlington Hall		23d. LOCATION (City, town, or county) (State) Arlington Va.	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers (Y/m)				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE AUG 3 '60	
						25b. REGISTRAR'S SIGNATURE Gail G. Kenna	



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FOR STATE  
HEALTH DEPT.

TO DEPT. OF STATE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
a. COUNTY				e. STATE			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				f. COUNTY			
c. LENGTH OF STAY IN 1b				g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				h. STREET ADDRESS			
Prince George's				Maryland			
Cheverly				Silver Spring			
Dead on arrival				1515.2			
Prince George's General Hospital				820 Northwest Drive			
First Middle Last				Date of Death			
Roland Clay De Launey SR.				July 23 19 60			
5. SEX				6. COLOR OR RACE			
Male				White			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				May 30, 1911			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if intermittent)				10b. KIND OF BUSINESS OR INDUSTRY			
Gov. Accounting Representative				Remington Rand			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Maryland				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George P. De Launey				Carrie Hamberry			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
Yes WW II				216-10-2269			
17. INFORMANT				Address			
Mrs. Romaine De Launey, same as #2							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				Acute congestive heart failure			
DUE TO (b)				Cardiovascular renal disease			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
Dr. James I. Boyd				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF			
BURIAL				7/27/60			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or country) (State)			
Arlington Nat'l. Cemetery				Arlington, Virginia			
23. FUNERAL DIRECTOR				24a. REC'D BY REGISTRAR			
WARNER E. PIMPHREY, INC.				24b. REGISTRAR'S SIGNATURE			
Raymond A. Ziska				DATE JUL 28 '60			
SILVER SPRING, MD.				Arthur S. Kraus			

88299



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Prince George's

Montgomery

Montgomery

Shaverly

Band on arrival

Silver Spring

Prince George's General Hospital 650 Northwest Drive

Johns

Gray

De Lannoy

July

May 30, 1911

White

Male

Remington Road

Maryland

U.S.A.

George F. De Lannoy

Johns Hopkins

Yes W 11

21-10-1911

Mr. Homeline De Lannoy, owner of

Acute congestive heart failure

Cardiovascular renal disease

Dr. James I. Boyd

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
08300

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheeverly</b>				c. LENGTH OF STAY IN 1b <b>18 da.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				d. STREET ADDRESS <b>4640 Lacey Ave</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>William A. Donaldson</b>				4. DATE OF DEATH Month Day Year <b>July 14 19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 8th 1887</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bricklayer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Wash. D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>James Donaldson</b>				14. MOTHER'S MAIDEN NAME <b>Emma Collins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>				16. SOCIAL SECURITY NO. <b>578-12-5600 A</b>		17. INFORMANT <b>James H. Donaldson (Son)</b>	
				605 42nd Street		Holly Park Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Thrombosis</b> DUE TO <b>Cerebral Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>18 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 27 1960</b> to <b>July 14 1960</b> that (I) (we) last saw the deceased alive on <b>July 14 1960</b> and that death occurred at <b>9:15 pm</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>William D. Rosson</b>				22b. DATE SIGNED <b>7/15/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM D. ROSSON, MD</b>				22d. ADDRESS <b>5304 ANNAPOLIS RD, Bladensburg, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/18/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Chambers Co. Inc.</b>				ADDRESS <b>517 11th St S.E.</b>		25a. REC'D BY REGISTRAR <b>Arthur S. Kraus</b>	
				DATE <b>JUL 19 60</b>			

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CERTIFICATE OF DEATH

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John Doe  
100 Main Street  
New York, N.Y.  
Born April 1, 1900  
Died April 1, 1980  
Cause of Death  
Age 80

John Doe  
100 Main Street  
New York, N.Y.  
Born April 1, 1900  
Died April 1, 1980  
Cause of Death  
Age 80

8297

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08301

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN 1b <b>19 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5303 42nd Avenue</b>				d. STREET ADDRESS <b>5303 42nd Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Louis</b> Middle <b>Simon</b> Last <b>Eichinger</b>				4. DATE OF DEATH Month <b>July</b> Day <b>6</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-1-60 1893</b>		9. AGE (In years last birthday) <b>67 yrs.</b>	IF UNDER 1 YEAR Months <b>6</b> Days <b>6</b>	IF UNDER 24 HRS. Hours <b>19</b> Min. <b>60</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cabinet making</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Paul Eichinger</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Jerge</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. 1 118-03-9332</b>		17. INFORMANT <b>Robert Eichinger; same address as # 2.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO <b>Cardiovascular renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>p. m.</b> <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>July 6, 1960</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Transportation</b>		<b>July 8, 1960</b>		<b>Lockport</b>		<b>New York</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville Maryland.</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 11 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12-10-1918

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED John Doe		AGE 45		SEX Male		RACE White		RELIGION Roman Catholic		MARRIAGE Married		EDUCATION High School		OCCUPATION Carpenter		RESIDENCE 123 Main St, Baltimore, Md.		DATE OF DEATH 12-10-1918		PLACE OF DEATH Home	
FATHER'S NAME John Doe		MOTHER'S NAME Mary Doe		BIRTH DATE 12-10-1873		BIRTH PLACE Baltimore, Md.		BIRTH TIME 10:00 AM		BIRTH WEIGHT 10 lbs		BIRTH LENGTH 20 in		BIRTH HEAD CIRCUMFERENCE 13 in		BIRTH SKIN COLOR Fair		BIRTH HAIR COLOR Brown		BIRTH EYE COLOR Blue	
PREVAILING DISEASE Pneumonia		CAUSE OF DEATH Pneumonia		MANNER OF DEATH Natural		PERIOD OF ILLNESS 1 week		SYMPTOMS Cough, fever, chest pain		TREATMENT Medicine, rest		PROGNOSIS Favorable		REMARKS Patient died peacefully		SIGNATURE OF EXAMINER Dr. J. Doe		DATE OF EXAMINATION 12-10-1918		PLACE OF EXAMINATION Home	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8324

CERTIFICATE OF DEATH

08302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevery</b>		c. LENGTH OF STAY IN 1b <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2810--63rd Ave.</b>		d. STREET ADDRESS <b>322 Ma ss. Ave. N.E.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>ELLINGTON</b> Last		4. DATE OF DEATH Month <b>JULY</b> Day <b>31</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 11, 1893</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Stone</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Geraldine Lawrence</b>		Address <b>2810-63rd Ave. CHEVERY MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b> 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 1959</b> to <b>July 31, 1960</b> , that I last saw the deceased alive on <b>July 30, 1960</b> , and that death occurred at <b>12:25 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William D. Rosson MD.</b>		ADDRESS (Street, city or town, state) <b>5304 ANNAPOLIS ROAD 7/31/60</b>	
PHYSICIAN'S NAME (Type) <b>WILLIAM D. ROSSON, MD.</b>		LOCATION (City, town, or county) (State) <b>BLADENSBURG, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-3-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cent.</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Wm. Lees</b>		ADDRESS <b>Wash. D.C.</b>	
24a. REC'D BY REGISTRAR <b>Aug 2 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kline</b>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

4124

Prince George

Cherry

1212 East Ave.

BRONX

DATE

NOV. 11, 1903

Age

Occupation

THE NEW YORK PUBLIC LIBRARY

ASTOR LENOX TILDEN FOUNDATION  
500 N. 5TH ST. NEW YORK

8325

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

08303

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>5 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH First <b>James</b> Middle <b>R</b> Last <b>Facer</b>				4. DATE OF DEATH Month <b>July</b> Day <b>23</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>16 Oct. 1885</b>	
9. AGE (In years lost birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>16</b> Hours <b>16</b> Min.		IF UNDER 24 HRS. Hours <b>16</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auditer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>		11. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Albert Facer</b>				14. MOTHER'S MAIDEN NAME <b>Lavinia Hammond</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NO</b>			
17. INFORMANT <b>Julia Yeabower</b>				Address <b>3602 Longfellow St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis (right parieto-occipital)</b> DUE TO <b>3322X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>years</b> <b>years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mitral Valvular Stenosis, old, cause undetermined.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>7-19</b> to <b>7-23</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>7-23</b> 19 <b>60</b> , and that death occurred on <b>7-30</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. R. Fleischer</b>				22b. DATE SIGNED <b>7/24/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. R. Fleischer M.D.</b>				22d. ADDRESS <b>4320 Avenue of the Americas, New York 17, N.Y.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>7/27/60</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Prince George Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Walter W. Deal</b>				25a. REC'D BY REGISTRAR <b>DATE JUL 26 '60</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

State of New York  
County of [illegible]

8552

10

11

12

[Illegible text, likely a death certificate form with fields for name, date, and location.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

8298

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

08304

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>2701 Connecticut Avenue, N.W., Wash. D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Maryland</b>		c. LENGTH OF STAY IN 1b <b>3 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Carroll Manor</b>		d. STREET ADDRESS <b>47 X-3</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mae</b> Middle <b>Quaid Ferguson</b> Last		4. DATE OF DEATH Month <b>7</b> - Day <b>14</b> - Year <b>60</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-19-92</b>
9. AGE (In years lost birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk-typist (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Govt.</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Patrick S. Quaid</b>		14. MOTHER'S MAIDEN NAME <b>Margaret McLaughlin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Margaret M. Quaid</b>		Address <b>2701 Connecticut Ave. N.W.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Fibrosis and Cardiac decompensation</b> DUE TO (c) <b>left mycotic (Aspergella Nigera) lung abscess</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 min.</b> <b>4 yrs.</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Baroncho - pleural - cutaneous fistula, left upper lobe</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 7-14 1960</b> , that (I) (we) last saw the deceased alive on <b>10:55 P.M. 7-14-60</b> , and that death occurred at <b>10:55 P.M.</b> causes and on the date stated above.			
22a. SIGNATURE <b>S. J. Cosimano, Jr., M.D.</b>		22b. DATE SIGNED <b>7-15-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>S. J. Cosimano, Jr., M.D.</b>		22d. ADDRESS <b>1835 Eye Street, N.W., Wash. 6, D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-18-1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet</b>		23d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Gawler's Sons, Inc. 1756 Pa. Ave. N.W.</b>		25a. REC'D BY REGISTRAR <b>DATE JUL 18 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			



CERTIFICATE OF DEATH

8238



Place of death  
Date of death  
Age at death  
Sex  
Race  
Cause of death  
Disease or condition  
Occupation  
Signature of physician  
Signature of registrar  
Date of registration  
Place of registration

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

8326

08305

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>9 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47 Mt. Rainier</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>3728 36th St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Irene</b> Middle <b>Elizabeth</b> Last <b>Fitzgerald</b>				4. DATE OF DEATH Month <b>July</b> Day <b>16</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>22 Dec. 1921</b>	
9. AGE (In years last birthday) <b>38</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		11. BIRTHPLACE (State or foreign country) <b>2nd St. Laundry Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Frank Williams</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Hager</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-28378</b>		17. INFORMANT <b>Florence E. Gidley Daughter</b> Address <b>above</b>			
18. CAUSE OF DEATH [Enter only one cause prevailing for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Melanotic Carcinoma</b> DUE TO <b>(terminal) origin site</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>terminal</b> DUE TO <b>terminal</b> (c) <b>terminal</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7-7-60</b> 19 <b>60</b> , to <b>7-16</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>7-15</b> 19 <b>60</b> , and that death occurred at <b>6.00A</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>W. L. Etienne</b>				22b. DATE SIGNED <b>7/16/60</b>		22c. PHYSICIAN'S NAME (Type) <b>W. L. Etienne</b>	
22d. ADDRESS <b>Coll. D.K. Jrs</b>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/19/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Colma Manor, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Kalley's Funeral Home</b>				ADDRESS <b>Mt. Rainier Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 20 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

MARYLAND DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

8352

11-20-1917

Harford

White male

Dr. Hamilton

2 days

University

Prince George's Hospital

From St. Elizabeth's

11-17-1917

Black  
Frank

28218  
St. Elizabeth's  
Hospital

Dr. Hamilton

11-17-1917

11-17-1917

11-17-1917

11-17-1917

11-17-1917

11-17-1917

11-17-1917

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-14  
15M 9-59

8327										MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH										08306									
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>																								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>					c. LENGTH OF STAY IN 1b <b>11 da.</b>					d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>					e. STREET ADDRESS <b>1</b>																								
3. NAME OF DECEASED (Type or print) First <b>Baby Boy</b> Middle <b>Fleets</b> Last <b>Fleets</b>					4. DATE OF DEATH Month <b>July</b> Day <b>6</b> Year <b>19 60</b>																								
5. SEX <b>M</b>		6. COLOR OR RACE <b>C.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6 - 25 - 60</b>		9. AGE (In years last birthday) <b>11</b>		IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min. <b>11</b>		IF UNDER 24 HRS.																	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <b>Maryland</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>														
13. FATHER'S NAME <b>Stanley Fleets</b>					14. MOTHER'S MAIDEN NAME <b>Lucy Arebella Smallwood</b>																								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. (If yes, give war or dates of service)					17. INFORMANT <b>Mother</b> Address <b>Same</b>																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>764.5</b> DUE TO <b>atelectasia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Pneumonia</b> (c) <b>Emphysema</b>										INTERVAL BETWEEN ONSET AND DEATH																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>					20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from <b>June 25</b> 19 <b>60</b> , to <b>July 6</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>July 6</b> 19 <b>60</b> and that death occurred at <b>10:10pm</b> the causes and on the date stated above.																													
22a. SIGNATURE <b>John W. Park</b>										M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <b>7-7-60</b>														
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE THEREOF <b>July 8, 1960</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Libby on Meacham Co. cemetery Md</b>					23d. LOCATION (City, town, or county) (State)														
24. FUNERAL DIRECTOR'S SIGNATURE <b>George H. Nelson</b>										ADDRESS <b>Crownsville Md</b>					25a. REC'D BY REGISTRAR <b>DATE JUL 11 '60</b>					25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>									

2077 309 XV 3

CERTIFICATE OF DEATH

STATE OF NEW YORK  
COUNTY OF ALBANY

8821

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1

8328

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

08307

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jessie</b> Middle <b>R</b> Last <b>Fraase</b>		4. DATE OF DEATH Month <b>July</b> Day <b>12</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 13, 1915</b>
9. AGE (In years last birthday) <b>44</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cosmetic Byer Drug Co</b>	11. BIRTHPLACE (State or foreign country) <b>New York</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Daniel Reiff</b>	
14. MOTHER'S MAIDEN NAME <b>Anna Worrell</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>578 09 5803</b>		17. INFORMANT Address <b>Erwin E Fraase Hyattsville Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>Coronary atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic</b> (c) <b>hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 14</b> 19 <b>60</b> to <b>July 12</b> 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>July 5</b> 19 <b>60</b> , and that death occurred at <b>6:15</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles C. Hageage</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Charles C. Hageage M.D.</b>		22d. ADDRESS <b>3308 Perry St. Mt. Rainier, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 14, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville Md.</b>		25a. REC'D BY REGISTRAR <b>JUL 15 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Orlino L. Haines</b>			

CERTIFICATE OF DEATH

1932

020

NAME OF DECEASED: Charles E. Foy  
AGE: 38 YEARS  
SEX: Male  
DATE OF BIRTH: October 13, 1894  
PLACE OF BIRTH: St. Louis, Mo.  
OCCUPATION: Engineer  
CAUSE OF DEATH: Heart disease  
DATE OF DEATH: October 13, 1932  
PLACE OF DEATH: St. Louis, Mo.  
SIGNATURE OF PHYSICIAN: [Signature]  
SIGNATURE OF WITNESSES: [Signature]  
SIGNATURE OF DECEASED: [Signature]

8384

## CERTIFICATE OF DEATH

08308

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Pr Geo</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Va</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ALEXANDRIA</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4518 ELMwood Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELIZA VERDE FRUM</u>		4. DATE OF DEATH <u>JULY 5 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 29-1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. Va.</u>	9. AGE (In years last birthday) <u>89</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN NELSON DORSON</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA COFFMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Lucille Rollin</u>		Address <u>Beltsville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>332X</u> DUE TO <u>Cerebral Thrombosis</u> DUE TO <u>Chr. Congestive Heart Failure</u> DUE TO <u>Generalized Arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <u>APR 6 1960</u> to <u>JULY 6 1960</u> that I last saw the deceased alive on <u>JUNE 27 1960</u> and that death occurred at <u>7 P</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>W. L. Etienne</u> M.D. <u>4713 BERLYN Rd</u> DATE SIGNED <u>7/5/60</u> PHYSICIAN'S NAME (Type) <u>W. L. ETIENNE</u> <u>College Park, Md</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL-BURIAL</u> 22b. DATE THEREOF <u>7/1/60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>OLD FELLOW CEMETERY</u> 22d. LOCATION (City, town, or county) (State) <u>WALLACE W. VA.</u> 23. FUNERAL DIRECTOR'S SIGNATURE <u>EVERLY-WHEATLEY FUNERAL HOME ALEXANDRIA, VA</u> ADDRESS <u>—</u> 24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08309

Reg. Dist. No.

8385

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Prince Georges</span> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Maryland</span> b. COUNTY <span style="font-size: 1.2em;">Prince Georges</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Rural-Adelphi</span>			c. LENGTH OF STAY IN 1b <span style="font-size: 1.2em;">5½ mos.</span>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Cheverly</span>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <span style="font-size: 1.2em;">Paint Branch Nursing Home</span>				d. STREET ADDRESS <span style="font-size: 1.2em;">3117 Cheverly Avenue</span>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print)      First      Middle      Last <span style="font-size: 1.2em;">Edith      Phoebe      Gaither</span>				<b>4. DATE OF DEATH</b> Month      Day      Year <span style="font-size: 1.2em;">July 20, 1960</span>			
<b>5. SEX</b> <span style="font-size: 1.2em;">Female</span>		<b>6. COLOR OR RACE</b> <span style="font-size: 1.2em;">white</span>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">Jan. 11, 1873</span>	
<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">87 yrs.</span>		<b>IF UNDER 1 YEAR</b> Months      Days      Hours      Min.		<b>IF UNDER 24 HRS.</b> Months      Days      Hours      Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Illinois</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA</span>			
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">George Brandenburg</span>				<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Unknown</span>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <span style="font-size: 1.2em;">No</span>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <span style="font-size: 1.2em;">Records of Nursing Home</span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b>  <span style="font-size: 1.5em;">442X</span> </div> <div style="width: 65%;"> <span style="font-size: 1.2em;">Acute congestive heart failure</span> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 30%;"> <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b> </div> <div style="width: 65%;"> <b>DUE TO (b)</b>  <span style="font-size: 1.2em;">Cardiovascular renal disease</span> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 30%;"> <b>DUE TO (c)</b> </div> <div style="width: 65%;"> </div> </div>							INTERVAL BETWEEN ONSET AND DEATH
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour      a. m.      p. m. <span style="font-size: 1.2em;">19</span>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County)      (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, (inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>ACTUAL SIGNATURE</b> <span style="font-size: 1.5em;">John T. Maloney</span>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <span style="font-size: 1.2em;">John T. Maloney, M.D.</span>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <span style="font-size: 1.2em;">July 19, 1960</span>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Burial</span>		<b>22b. DATE THEREOF</b> <span style="font-size: 1.2em;">July 23, 1960</span>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Ft Lincoln Cemetery</span>		<b>22d. LOCATION (City, town, or county)</b> (State) <span style="font-size: 1.2em;">Colmar Manor, Md.</span>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <span style="font-size: 1.2em;">F. Gasch's Sons      Hyattsville, Maryland.</span>				<b>24a. REC'D BY REGISTRAR</b> <span style="font-size: 1.2em;">DATE JUL 25 '60</span>		<b>24b. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.2em;">Arthur J. Frank</span>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [Name]		2. SEX [Male]	
3. AGE [Age]		4. DATE OF BIRTH [Date]	
5. PLACE OF BIRTH [Place]		6. OCCUPATION [Occupation]	
7. MARITAL STATUS [Status]		8. EDUCATION [Education]	
9. PRESENT ADDRESS [Address]		10. DATE OF DEATH [Date]	
11. CAUSE OF DEATH [Cause]		12. MANNER OF DEATH [Manner]	
13. SIGNATURE OF MEDICAL EXAMINER [Signature]		14. SIGNATURE OF WITNESS [Signature]	
15. SIGNATURE OF CORONER [Signature]		16. SIGNATURE OF JURY [Signature]	
17. SIGNATURE OF DECEASED [Signature]		18. SIGNATURE OF NEXT OF KIN [Signature]	
19. SIGNATURE OF SURGEON [Signature]		20. SIGNATURE OF DENTIST [Signature]	
21. SIGNATURE OF PHARMACEUTICIAN [Signature]		22. SIGNATURE OF NURSE [Signature]	
23. SIGNATURE OF MIDWIFE [Signature]		24. SIGNATURE OF OTHER [Signature]	
25. SIGNATURE OF OTHER [Signature]		26. SIGNATURE OF OTHER [Signature]	
27. SIGNATURE OF OTHER [Signature]		28. SIGNATURE OF OTHER [Signature]	
29. SIGNATURE OF OTHER [Signature]		30. SIGNATURE OF OTHER [Signature]	
31. SIGNATURE OF OTHER [Signature]		32. SIGNATURE OF OTHER [Signature]	
33. SIGNATURE OF OTHER [Signature]		34. SIGNATURE OF OTHER [Signature]	
35. SIGNATURE OF OTHER [Signature]		36. SIGNATURE OF OTHER [Signature]	
37. SIGNATURE OF OTHER [Signature]		38. SIGNATURE OF OTHER [Signature]	
39. SIGNATURE OF OTHER [Signature]		40. SIGNATURE OF OTHER [Signature]	
41. SIGNATURE OF OTHER [Signature]		42. SIGNATURE OF OTHER [Signature]	
43. SIGNATURE OF OTHER [Signature]		44. SIGNATURE OF OTHER [Signature]	
45. SIGNATURE OF OTHER [Signature]		46. SIGNATURE OF OTHER [Signature]	
47. SIGNATURE OF OTHER [Signature]		48. SIGNATURE OF OTHER [Signature]	
49. SIGNATURE OF OTHER [Signature]		50. SIGNATURE OF OTHER [Signature]	
51. SIGNATURE OF OTHER [Signature]		52. SIGNATURE OF OTHER [Signature]	
53. SIGNATURE OF OTHER [Signature]		54. SIGNATURE OF OTHER [Signature]	
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59. SIGNATURE OF OTHER [Signature]		60. SIGNATURE OF OTHER [Signature]	
61. SIGNATURE OF OTHER [Signature]		62. SIGNATURE OF OTHER [Signature]	
63. SIGNATURE OF OTHER [Signature]		64. SIGNATURE OF OTHER [Signature]	
65. SIGNATURE OF OTHER [Signature]		66. SIGNATURE OF OTHER [Signature]	
67. SIGNATURE OF OTHER [Signature]		68. SIGNATURE OF OTHER [Signature]	
69. SIGNATURE OF OTHER [Signature]		70. SIGNATURE OF OTHER [Signature]	
71. SIGNATURE OF OTHER [Signature]		72. SIGNATURE OF OTHER [Signature]	
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77. SIGNATURE OF OTHER [Signature]		78. SIGNATURE OF OTHER [Signature]	
79. SIGNATURE OF OTHER [Signature]		80. SIGNATURE OF OTHER [Signature]	
81. SIGNATURE OF OTHER [Signature]		82. SIGNATURE OF OTHER [Signature]	
83. SIGNATURE OF OTHER [Signature]		84. SIGNATURE OF OTHER [Signature]	
85. SIGNATURE OF OTHER [Signature]		86. SIGNATURE OF OTHER [Signature]	
87. SIGNATURE OF OTHER [Signature]		88. SIGNATURE OF OTHER [Signature]	
89. SIGNATURE OF OTHER [Signature]		90. SIGNATURE OF OTHER [Signature]	
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93. SIGNATURE OF OTHER [Signature]		94. SIGNATURE OF OTHER [Signature]	
95. SIGNATURE OF OTHER [Signature]		96. SIGNATURE OF OTHER [Signature]	
97. SIGNATURE OF OTHER [Signature]		98. SIGNATURE OF OTHER [Signature]	
99. SIGNATURE OF OTHER [Signature]		100. SIGNATURE OF OTHER [Signature]	

# 1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

See: Birth Cert. et

## CERTIFICATE OF DEATH

Reg. Dist. No.

08310

8329

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>3 da</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Baby Boy</b> <b>A</b>				4. DATE OF DEATH <b>June 20 19 60</b>			
5. SEX <b>boy</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-17-60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Cheverly, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ned De Vere Gilmore</b>				14. MOTHER'S MAIDEN NAME <b>Frances L. Rawlings</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>762.5</b> DUE TO <b>Abductor</b> <b>Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 17, 1960</b> , to <b>June 20, 1960</b> , that I last saw the deceased alive on <b>June 20, 1960</b> , and that death occurred at <b>6:00pm</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John W. Perkins</b>				ADDRESS (Street, city or town, state) <b>5301 Hamilton St., Hyattsville, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Dr. John W. Perkins MD.</b>				DATE SIGNED <b>21/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>7-18-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's Gen. Hosp. Cheverly, MARYLAND</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr. Administrator</b>				24a. REC'D BY REGISTRAR <b>JUL 25 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneass</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AT5 (4)  
ISM 9/59

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8386  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAWN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7019-FREEPORT ST</u>		d. STREET ADDRESS <u>7019-FREEPORT ST</u>	
3. NAME OF DECEASED (Type or print) <u>LLOYD LEROY GRAHAM</u>		4. DATE OF DEATH <u>JULY 31 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 30 1908</u> 51 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>US Gov. LIBRARY CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PA.</u>	
13. FATHER'S NAME <u>CLARENCE GRAHAM</u>		14. MOTHER'S MAIDEN NAME <u>MARY ANN HOAR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>WORLD II</u>		16. SOCIAL SECURITY NO. <u>7019-7019</u>	
17. INFORMANT <u>MRS MARIE E. GRAHAM</u> Address <u>WIFE</u>		18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Cardio Vascular Disease</u> 442x DUE TO <u>sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>7 months</u> DUE TO (c) <u>7 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinson's Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3 Jan 60</u> to <u>29 July 1960</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>29 July 1960</u> , and that death occurred at <u>12 noon</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert C Haile</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT C. HAILE</u>		22d. ADDRESS <u>35 N 4 Ave NW Wash DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>8/3/60</u>		23b. DATE THEREOF <u>8/3/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>		23d. LOCATION (City, town, or county) (State) <u>SUITLAND MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Helene Home</u>		25a. REC'D BY REGISTRAR <u>DATE AUG 3 '60</u>	
ADDRESS <u>300-4 ST NE DC.</u>		25b. REGISTRAR'S SIGNATURE <u>C. L. K. K.</u>	

1918

(1)

(2)

First Name: [illegible]  
Last Name: [illegible]  
Sex: [illegible]  
Age: [illegible]  
Date of Birth: [illegible]  
Place of Birth: [illegible]  
Cause of Death: [illegible]  
Date of Death: [illegible]  
Place of Death: [illegible]  
Signature: [illegible]  
Witness: [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove proper papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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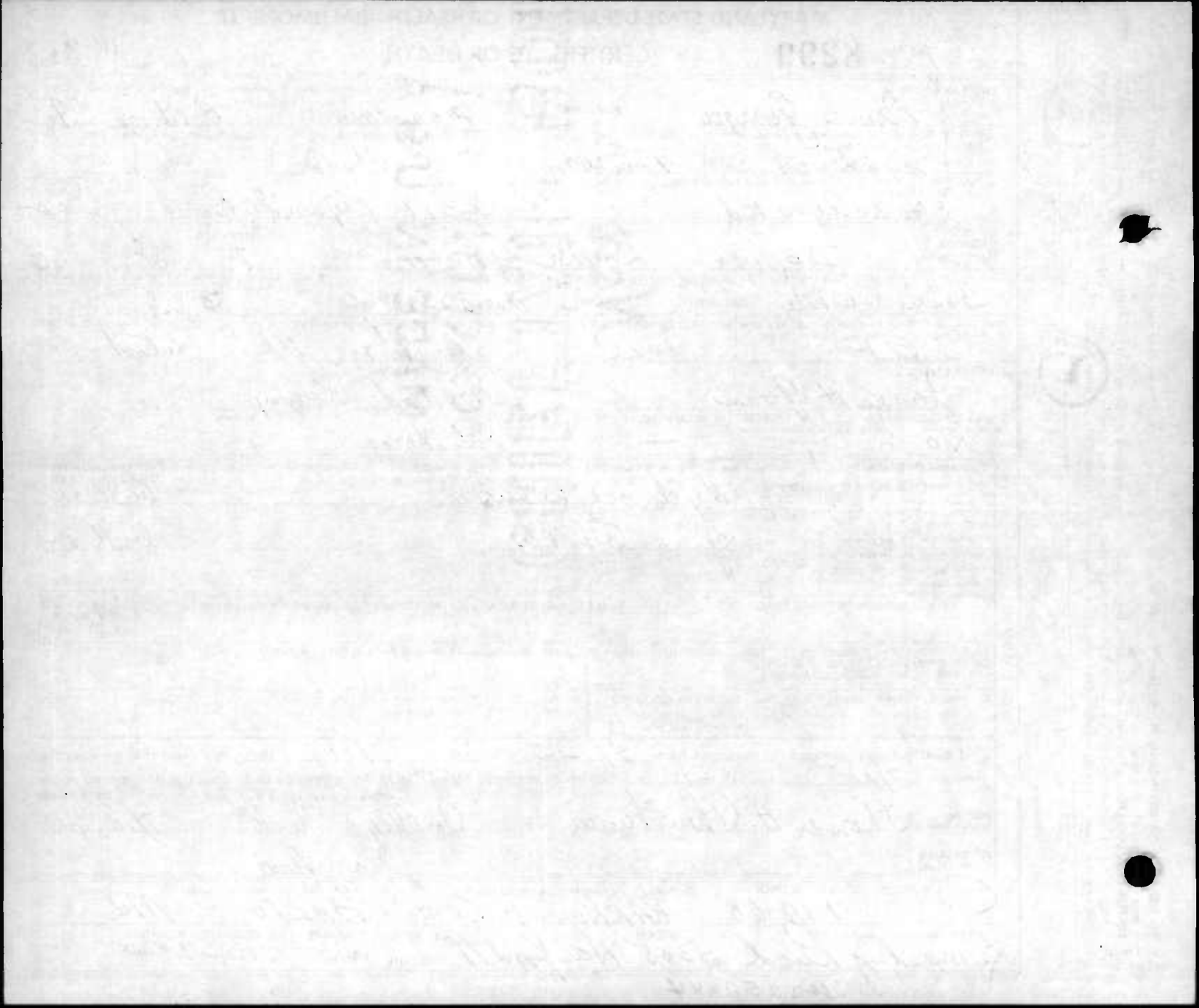
CERTIFICATE OF DEATH

Reg. Dist. No.

108312

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	c. LENGTH OF STAY IN 1b <u>4 years 24 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6403 Agor Rd</u>		d. STREET ADDRESS <u>5318 Plymouth Road</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Denise</u> Middle <u>Louise</u> Last <u>Green</u>		4. DATE OF DEATH Month <u>7</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 25, 1960</u>
9. AGE (In years lost birthday) yrs. <u>3</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>24</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		13. FATHER'S NAME <u>James H Green</u>	
14. MOTHER'S MAIDEN NAME <u>Nildred Kenny</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u></u>	
16. SOCIAL SECURITY NO. <u></u>		INFORMANT <u>History</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephalus</u> 751X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Spina Bifida</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>Birth on</u> <u>Birth on</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/25</u> , 19 <u>60</u> , to <u>7/18</u> , 19 <u>60</u> that I last saw the deceased alive on <u>7/18</u> , 19 <u>60</u> , and that death occurred at <u>12:45</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas A. Christensen</u> M.D.		ADDRESS (Street, city or town, state) <u>College Park</u> DATE SIGNED <u>7/18/60</u>	
PHYSICIAN'S NAME (Type) <u>Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>7-19-60</u>	22b. DATE THEREOF <u>7-19-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD Cem</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Luck</u> ADDRESS <u>5305 Harford Rd</u>		24a. REC'D BY REGISTRAR <u>JUL 21 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

08313

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> <span style="float:right">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>P. G.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>Dead on arrival</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chillum</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>702 Chillum Road</b>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Louis</b> Middle <b>Edward</b> Last <b>Gross</b>				<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>24</b> Year <b>19 60</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>October 25, 1867</b>	
<b>9. AGE</b> (In years last birthday) <b>73</b> yrs.		<b>IF UNDER 1 YEAR</b> Months      Days      Hours      Min.		<b>IF UNDER 24 HRS.</b> Hours      Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Chiropractor</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Retired</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>New York</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>Unknown Harry Gross</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown Rachel</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>577-54-1168</b>		<b>17. INFORMANT</b> <b>Harold Gross, 5557 Chillum Place NE Washington, D.C.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO (b) <b>Cardiovascular renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour      a. m.      p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <i>James I. Boyd</i>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <b>James I. Boyd</b>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>22b. DATE THEREOF</b> <b>7-26-60</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>ME. LEBANON CEMETERY</b>		<b>22d. LOCATION (City, town, or county) (State)</b> <b>HYATTSVILLE M.D.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>B. PANZANSKY &amp; SONS</b>				<b>ADDRESS</b> <b>3501-14th ST. N.W.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>JUL 27 '60</b>	
				<b>24b. REGISTRAR'S SIGNATURE</b> <i>John S. Hunt</i>		<b>DATE SIGNED</b> <b>July 24, 1960</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
John Doe		Male		45		1945	
PLACE OF DEATH		CITY OF BALTIMORE		COUNTY		STATE	
John Doe		Baltimore		Baltimore		Maryland	
PLACE OF BIRTH		CITY OF BALTIMORE		COUNTY		STATE	
John Doe		Baltimore		Baltimore		Maryland	
RACE		WHITE		SEX		MALE	
John Doe		White		Male		Male	
OCCUPATION		FARMER		EDUCATION		HIGH SCHOOL	
John Doe		Farmer		Education		High School	
MANNER OF DEATH		NATURAL		CAUSE OF DEATH		HEART DISEASE	
John Doe		Natural		Cause of Death		Heart Disease	
PLACE OF DEATH		CITY OF BALTIMORE		COUNTY		STATE	
John Doe		Baltimore		Baltimore		Maryland	
PLACE OF BIRTH		CITY OF BALTIMORE		COUNTY		STATE	
John Doe		Baltimore		Baltimore		Maryland	
RACE		WHITE		SEX		MALE	
John Doe		White		Male		Male	
OCCUPATION		FARMER		EDUCATION		HIGH SCHOOL	
John Doe		Farmer		Education		High School	
MANNER OF DEATH		NATURAL		CAUSE OF DEATH		HEART DISEASE	
John Doe		Natural		Cause of Death		Heart Disease	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

8372

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08314

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Chillum</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>			d. STREET ADDRESS <b>843 Berkshire Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Margaret</b> Last <b>Grossman</b>			4. DATE OF DEATH Month <b>July</b> Day <b>1st</b> Year <b>1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-23-14</b>	9. AGE (In years last birthday) <b>46</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife -Saleslady</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. store</b>		11. BIRTHPLACE (State or foreign country) <b>Scotland</b>	
13. FATHER'S NAME <b>William Sterling</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Irving</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>384-18-8145</b>		17. INFORMANT <b>Mrs. LeRoy S. Girson; 7204 Brennan Lane Chevy Chase Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Congestive heart failure</b> (c) <b>Myocardosis</b> DUE TO couse lost.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>July 2, 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>7/5/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CREMATORY</b>	
22d. LOCATION (City, town, or county) <b>PRINCE GEO. COUNTY, MD.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Pumphrey, INC.</b>		ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>JUL 6 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>					



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

8373

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08315

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4409 Queensbury Road		d. STREET ADDRESS 4409 Queensbury Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last James Russell Hansher		4. DATE OF DEATH July 4 1960	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 23, 1902
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician (retired)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? usa	
13. FATHER'S NAME Robert Hansher		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 508-10-7090	
17. INFORMANT Peggy Mello; 126 34th St., S.E., Wash., D.C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442 X Acute congestive heart failure DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED July 5, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 7, 196-	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Suitland Md	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE JUL 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Haux	

**MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE 10**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

NAME OF DECEASED Robert [illegible]		SEX Male		AGE 45		DATE OF BIRTH 10-1-1900		PLACE OF BIRTH [illegible]	
OCCUPATION [illegible]		MARITAL STATUS Married		COLOR White		HEIGHT 5' 10"		WEIGHT 170	
EDUCATION High School Graduate		RELIGION Catholic		ETHNIC ORIGIN [illegible]		BUILD Medium		HAIR Brown	
PRESENT ADDRESS [illegible]		LAST KNOWN ADDRESS [illegible]		DATE OF DEATH 10-23-1940		TIME OF DEATH 10:00 AM		PLACE OF DEATH [illegible]	
CAUSE OF DEATH [illegible]		MANNER OF DEATH Natural		SIGNATURE OF EXAMINER [illegible]		TITLE OF EXAMINER Medical Examiner		DATE OF EXAMINATION 10-23-1940	
SIGNATURE OF NEXT OF KIN [illegible]		SIGNATURE OF WITNESS [illegible]		SIGNATURE OF DECEASED [illegible]		SIGNATURE OF EXAMINER [illegible]		SIGNATURE OF WITNESS [illegible]	

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08316

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edward Eugene Hardy</b>		4. DATE OF DEATH Month Day Year <b>July 13, 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-23-24</b>
9. AGE (In years last birthday) <b>35</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dental technician</b>	11. BIRTHPLACE (State or foreign country) <b>Alabama</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Houston H. Hardy</b>	
14. MOTHER'S MAIDEN NAME <b>Emma Prichard</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>W.W.2.</b>	
16. SOCIAL SECURITY NO. <b>262-26-8754</b>		17. INFORMANT Address <b>Eloisa Hardy; same address as # 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO <b>Cardiovascular renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>442x</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>John T. Maloney</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>July 14, 1960</b>	
22a. BURIAL, CREMATION, REMOVAL, ETC. <b>7/15/60</b>		22b. NAME OF CEMETERY OR CREMATORY <b>Barton F. uneral Home</b>	
22c. LOCATION (City, town, or county) <b>Atmore</b>		(State) <b>Alabama</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 18 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

Removal certificate





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

8332

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08317

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesverly</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47 Mt. Rainier</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Emma M. Haven</b>		4. DATE OF DEATH Month Day Year <b>July 10, 19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar 11, 1888</b>
9. AGE (In years lost birthday) <b>72</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Checker</b>	
11. BIRTHPLACE (State or foreign country) <b>La Salle Colorado</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Daniel Hubbard</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Parks</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>same as above</b>	
17. INFORMANT <b>Mrs. Inez Lemerick</b>		Address <b>same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>3322X Cerebral thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 17</b> 19 <b>60</b> to <b>July 10</b> 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>July 10</b> 19 <b>60</b> , and that death occurred at <b>1:25 P</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas G. Maloney</b>		22b. DATE SIGNED <b>10 Jul 60</b>	
22c. PHYSICIAN'S NAME (Type) <b>THOMAS G. MALONEY</b>		22d. ADDRESS <b>4814 - 71st AVE. WOODLAWN HYATTSVILLE, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>7/13/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		23d. LOCATION (City, town, or county) (State) <b>Gemar Manor, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Malley's Funeral Home</b>		25. REC'D BY REGISTRAR <b>JUL 14 '60</b>	
ADDRESS <b>mt. Rainier md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

CERTIFICATE OF DEATH

0887

Place of Birth: [illegible]  
Age: [illegible]  
Sex: [illegible]  
Date of Birth: [illegible]  
Date of Death: [illegible]  
Cause of Death: [illegible]  
Place of Death: [illegible]  
Signature: [illegible]  
Date: [illegible]

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VS A15 (4)  
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8387

## CERTIFICATE OF DEATH

08318

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Pr. Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenarden		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Glenarden	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 301 Johnson Ave		d. STREET ADDRESS 1301 Johnson Ave	
3. NAME OF DECEASED (Type or print) Robert First Middle Last Hawkins		4. DATE OF DEATH July 12 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 9 1878 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY Fed Govt	
13. FATHER'S NAME Charles Hawkins		14. MOTHER'S MAIDEN NAME Jane Purdy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-5688	
17. INFORMANT Gen. Hawkins		Address Glenarden, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 DUE TO Congestive Heart Failure (b) Hypertension (c) Pneumonitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 mos unknown 2 mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 12 1960, to July 12 1960, that I last saw the deceased alive on June 12 1960, and that death occurred at 9:40 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Henry C. Wise Jr. M.D.		ADDRESS (Street, city or town, state) 9405 Valt St. Lanham, Md.	
PHYSICIAN'S NAME (Type) Henry A. Wise Jr.		DATE SIGNED 7/19/60	
22a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		22b. DATE THEREOF 7-16-1960	
22c. NAME OF CEMETERY OR CREMATORY Carver Memorial		22d. LOCATION (City, town, or county) (State) Prince George Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE William Spangler		24a. REC'D BY REGISTRAR DATE JUL 15 1960	
ADDRESS 524-8-St N.E. DC		24b. REGISTRAR'S SIGNATURE Robert S. Thomas	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 77 hours after death.

VR A15 (4)  
ISM 9/59

8300  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

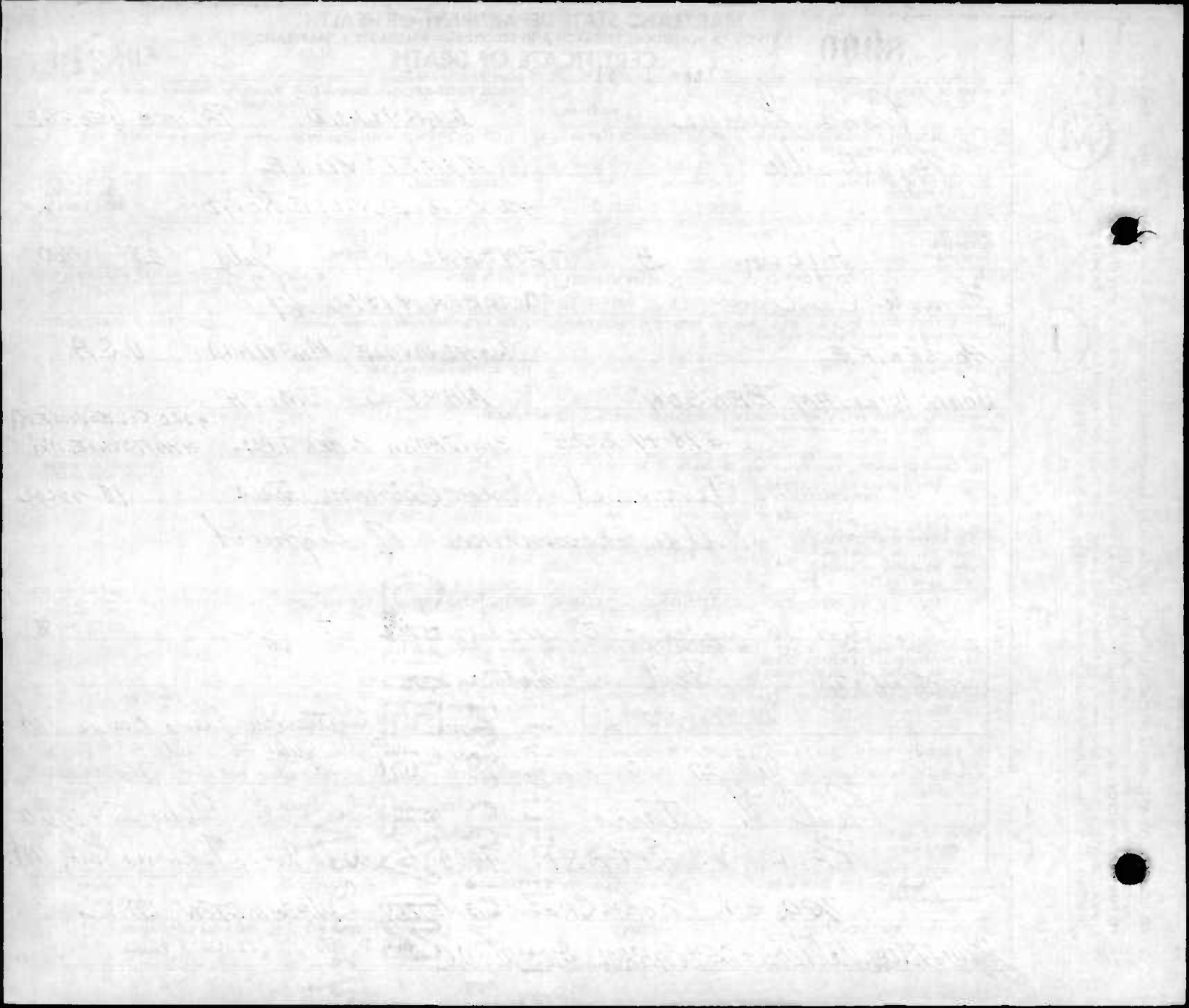
CERTIFICATE OF DEATH

Item 1 Film 268 8-4-60 et

08319

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>64 HYATTSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private Res. (4200 Colesville Road)</u>		d. STREET ADDRESS <u>4200 COLESVILLE ROAD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HILDA</u> Middle <u>B.</u> Last <u>HENSHALL</u>		4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCTOBER 14, 1892</u>
9. AGE in years (If UNDER 1 YEAR, IF UNDER 24 HRS. lost birthday) <u>67</u> yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>LAYTONSVILLE MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN WILLIAM BENSON</u>		14. MOTHER'S MAIDEN NAME <u>MARY S. SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-44-2225</u>	
17. INFORMANT <u>BENJAMIN H. HENSHALL</u>		Address <u>4200 COLESVILLE RD HYATTSVILLE MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Adenocarcinomatosis</u> <u>153.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Adenocarcinoma of Sigmoid</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>18 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Laceration rt. eyebrow &amp; ecchymosis rt. eye</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>not related</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in bathroom</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Hyattsville Prince Georges Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1958</u> to <u>July 28, 1960</u> , that (I) (we) last saw the deceased alive on <u>July 27, 1960</u> , and that death occurred at <u>2:17 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Paul V. Starr</u>		22b. DATE <u>July 28-1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>PAUL V. STARR</u>		22d. ADDRESS <u>7600 Canoll Ave., Takoma Park, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>7/30/60</u>		23b. DATE THEREOF <u>7/30/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>AUG 1 '60</u>	
ADDRESS <u>254 CARROLL ST. NW - D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8388

CERTIFICATE OF DEATH

08320

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville, Md</b>				c. LENGTH OF STAY IN 1b <b>7 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>11038 Montgomery Road</b>				d. STREET ADDRESS <b>11038 Montgomery Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Tressie</b>		First <b>Estella</b>		Middle <b>Holmes</b>		Last	
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 17, 1880</b>	
9. AGE (In years last birthday) <b>80</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		9. DATE OF DEATH <b>July 1, 1960</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Sylvanus Mayfield</b>				14. MOTHER'S MAIDEN NAME <b>Alice Murphyn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		INFORMANT <b>Charles Holmes</b> Address <b>Beltsville, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-sclerotic heart disease</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 10, 1960</b> to <b>July 1, 1960</b> , that I lost s/he the deceased alive on <b>July 1, 1960</b> and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4713 Barwood Rd College Park, Md</b> DATE SIGNED ACTUAL SIGNATURE <b>W. L. Etienne</b> M.D. PHYSICIAN'S NAME (Type) <b>W. L. ETIENNE</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/5/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 5 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

• 180 • 0118748200

Also known as

[illegible]

ENGLISH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8293  
CERTIFICATE OF DEATH

Reg. Dist. No.

118321

1. PLACE OF DEATH a. COUNTY <u>PR. GEO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Pittston, PA</u>	
c. LENGTH OF STAY IN 1b <u>2 yr</u>		d. STREET ADDRESS <u>1674-1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4910 Edgewood Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>LABARRE</u> Last <u>HOOVER</u>		4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 7, 1877</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac Labarre</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Grier</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Hoover (Husband)</u>		Address <u>Same as # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>HYPERTENSION</u> DUE TO (c) <u>CEREBRAL ARTERIOSCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN</u> , 19 <u>59</u> , to <u>JULY</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>JUNE 25</u> , 19 <u>60</u> , and that death occurred at <u>2:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.L. Etienne</u>		DATE SIGNED <u>7/3/60</u>	
PHYSICIAN'S NAME (Type) <u>W.L. ETIENNE</u>		ADDRESS (Street, city or town, state) <u>4713 BERWYN RD COLLEGE PARK, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/5/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pittston Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pittston Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 5 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS AIS (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

8389

08322

1. PLACE OF DEATH o. COUNTY <b>PRINCE GEORGE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>WASH. D.C.</b> b. COUNTY <b>42X-3</b>	
6. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>W. HYATTSDVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASH. D.C.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOME.</b>		d. STREET ADDRESS <b>717-2<sup>ND</sup> ST. N.E.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>HORAN</b> Last <b>HORAN</b>		4. DATE OF DEATH Month <b>7</b> Day <b>12</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/19/1877</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>11</b> Days <b>23</b> Hours <b>12</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>	
11. BIRTHPLACE (State or foreign country) <b>IRELAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN ROHAN</b>		14. MOTHER'S MAIDEN NAME <b>ELLEN DOWD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, ground down) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>SACRED HEART HOME - HYATTSDVILLE</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS C</b> DUE TO <b>MYOCARDIAL INFARCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> (c) <b>15 years</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 11</b> , 19 <b>42</b> , to <b>July 12</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>July 11</b> , 19 <b>60</b> , and that death occurred at <b>7:22</b> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>322 - H ST NE</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Thomas F Collins</b>		M.D. <b>322 - H ST NE</b>	
PHYSICIAN'S NAME (Type) <b>THOMAS F COLLINS</b>		<b>322 - H ST NE</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/15/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET</b>		22d. LOCATION (City, town, or county) (State) <b>WASH. D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Timothy Hannon - 3831 - GA. AVE.</b>		24. REC'D BY REGISTRAR DATE <b>JUL 22 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>William S. Hannon</b>			

CERTIFICATE OF DEATH

8127

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
John A. Smith		Male		45		1880-03-15		Boston, Mass.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
123 Main St., Boston		Carpenter		Heart Disease		Natural		Home	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTES OF DEATH		SECOND OF DEATH	
1910-05-10		10:30 AM		10		30		00	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		TIME OF SIGNATURE		HOUR OF SIGNATURE		MINUTES OF SIGNATURE		SECOND OF SIGNATURE	
1910-05-10		11:00 AM		11		00		00	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 1910

1  
FOR STATE  
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, 3, and 4 to the Funeral Director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8333

08323

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Sarah</b>		First Middle Last <b>Frances HORSMAN</b>		4. DATE OF DEATH <b>July 22 1960</b>		5. SEX <b>Female</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12 Oct. 1887</b>		9. AGE (In years last birthday) <b>72</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edwin Muse</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane Hankins</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Frances Arnold (Dau)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO (b) <b>Cardiovascular renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes</b>						INTERVAL BETWEEN ONSET AND DEATH	
20a. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>		EXAMINER'S NAME (Type) <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>July 23, 1960</b>	
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 25, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Trinity Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Collington Maryland.</b>	
23. FUNERAL DIRECTOR ADDRESS <b>F. Gasch's Sons Hyattsville, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 26 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

5

1

2023

DATE . I 2016

July 25, 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

8334

08325

1. PLACE OF DEATH o. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>5 Days</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>6417 40th Ave.</b>					
3. NAME OF DECEASED (Type or print) <b>Thomas J Huddleston</b>				4. DATE OF DEATH <b>July 11 19 60</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 6, 1903</b>			
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Automobiles</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>									
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Tyler</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b></b>					
17. INFORMANT <b>Eleanore L Huddleston</b>				Address <b>University Park, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular thrombosis</b> DUE TO <b>332X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>cerebral arterio sclerosis</b> DUE TO (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>cardiovascular heart disease</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>1 year</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>May 5th 1958</b> to <b>July 11 1960</b> , that (I) (we) last saw the deceased alive on <b>July 11 1960</b> , and that death occurred at <b>3:25P</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Till Bergman</b>				22b. DATE SIGNED <b>July 11, 1960</b>					
22c. PHYSICIAN'S NAME (Type) <b>Dr. Till Bergman, M.D.</b>				22d. ADDRESS <b>4314 Gallatin St. Hyattsville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 14, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Colmar Manor Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville Md.</b>		25a. REC'D BY REGISTRAR <b>JUL 15 '60</b>			
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>					



1883

CERTIFICATE OF DEATH

County of ... State of ...

On the ... day of ... 1883

at the residence of the deceased

John Doe

aged ... years

born ...

of the County of ... State of ...

who died on the ... day of ... 1883

at the residence of the deceased

John Doe

aged ... years

born ...

of the County of ... State of ...

who died on the ... day of ... 1883

at the residence of the deceased

John Doe

aged ... years

born ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08326 ✓

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. LENGTH OF STAY IN 1b <u>3 yrs 7 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR SANITARIUM</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>TERESA</u> Middle <u>MRS.</u> Last <u>HUSTED</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>26</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-15-62</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs. <u>97</u>
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JOHN MANNING</u>		14. MOTHER'S MAIDEN NAME <u>MARY Fallow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Sister Mary Agnes</u>		Address <u>4922 La Salle Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE 12 years</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>SEP 14 1948</u> to <u>July 26 1960</u> , that (I) (we) last saw the deceased alive on <u>July 26 1960</u> , and that death occurred at <u>7:30</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas F Collins</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. COLLINS</u>		22d. ADDRESS <u>322 H ST NE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>7-29-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GLEN WOOD CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>WASHINGTON, DC.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jas. Paulino</u>		25a. REC'D BY REGISTRAR <u>JUL 29 '60</u>	
ADDRESS <u>1756 Pa. Ave. N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

8-10-1



ARTERIO SCLEROTIC HEART DISEASE  
CONGESTIVE HEART FAILURE

2001-10-10

John H. Collins

THOMAS H. COLLINS

may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
8335  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
08327

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington D.C.</b>			
c. LENGTH OF STAY IN 1b <b>29 da.</b>				d. STREET ADDRESS <b>6503 K. St.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Rosetta V. Jackson</b>				4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>C.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-10-98</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		10. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				13. FATHER'S NAME <b>Walter Shanks</b>			
14. MOTHER'S MAIDEN NAME <b>Blanche Butler</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Jefferson Hgts. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260X Acute pyelonephritis &amp; abscess</b> DUE TO (b) <b>bronchopneumonia left</b> DUE TO (c) <b>hepatitis (icteric) (Ch.)</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1</b> 19 <b>60</b> to <b>July 29</b> 19 <b>60</b> , that (I) (we) lost saw the deceased alive on <b>July 29</b> 19 <b>60</b> , and that death occurred at <b>4:30 pm</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. C. James Duke</b>				22b. DATE SIGNED <b>7/30/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. C. James Duke, M.D.</b>	
22d. ADDRESS <b>6607 Riverdale Road Riverdale, Md.</b>				22e. REC'D BY REGISTRAR <b>MS 2 '60</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>8-2-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Carver Memorial Park Beltsville Md.</b>	
23d. LOCATION (City, town, or county) <b>Beltsville Md.</b>				24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Rollins</b> ADDRESS <b>4339 Hunt Pk. N.E.</b>			
25a. REC'D BY REGISTRAR <b>MS 2 '60</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

CERTIFICATE OF DEATH

DATE

Yours truly,  
[Signature]

Given by  
[Signature]

Witnessed by  
[Signature]

Witnessed by  
[Signature]

Witnessed by  
[Signature]

Witnessed by  
[Signature]

Witnessed by  
[Signature]

Witnessed by  
[Signature]

*[Faint, illegible handwritten text, possibly a signature or address]*

Witnessed by  
[Signature]

Witnessed by  
[Signature]

Witnessed by  
[Signature]

Witnessed by  
[Signature]



1  
FOR STATE  
HEALTH DEPT.

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
8336 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08328

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>Dead on arrival</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2828 Potee Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Jasper Flemming Johnson</b> First Middle Last			4. DATE OF DEATH <b>July 25, 1960</b> Month Day Year		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>10/15/23</b>		9. AGE (In years last birthday) <b>36</b> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Hauling</b>		
11. BIRTHPLACE (State or foreign country) <b>Dunn's N.C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Bleach Johnson</b>			14. MOTHER'S MAIDEN NAME <b>Stella Sanders</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)			16. SOCIAL SECURITY NO. <b>217-24-7323</b>		
17. INFORMANT Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO (b) <b>Coronary insufficiency, atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Cardiovascular renal disease</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>James I. Boyd</b>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>James I. Boyd</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			DATE SIGNED <b>7/25/60</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>7/27/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pisgah</b>	
22d. LOCATION (City, town, or country) (State) <b>Dunn N.C.</b>					
23. FUNERAL DIRECTOR <b>Arington S. Phillips</b>			24a. REGISTRATION DATE <b>7/29/60</b>		
ADDRESS <b>1848 N. Monmouth Baltimore 17, Md.</b>			24b. REGISTRAR'S SIGNATURE <b>Arington S. Phillips</b>		

(M)

(1)

Prince George's

Marjorie

Overly

Dead on arrival

Prince George's General Hospital 1828 Ford Street

Lester Williams Johnson July 25, 1960

Male Colored

10/15/63

35

Chenille

Reoline

James H. G. M. S. A.

21111 24444

217-24-1727

Acute congestive heart failure

Coronary insufficiency, atherosclerosis

Cardiovascular renal disease

James I. Boyd

7/25/60

217-24-1727

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2  
1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8337  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
08329

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>1 hr</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adelphi</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>2302 Metzertott Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Robie Bradley Johnson</b>				4. DATE OF DEATH <b>July 23 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/7/04</b>	
9. AGE (In years lost birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>self Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Murray Kentucky</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>James Bradley</b>				14. MOTHER'S MAIDEN NAME <b>Ophelia Douglas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Earle B Johnson</b> Address <b>Washington D. C.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arterio sclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>July 17 1960</b> to <b>July 23 1960</b> , that (I) (we) last saw the deceased alive on <b>July 23 1960</b> , and that death occurred at <b>8:15 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>W. L. Etienne</b>				22b. DATE SIGNED <b>7-23-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>W. L. ETIENNE</b>				22d. ADDRESS <b>College Park, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/26/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Charlottesville, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasdh's Sons</b> ADDRESS <b>Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR <b>AUG 1 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

10

1

0-33

CERTIFICATE OF DEATH

10-33

John Doe

John Doe

John Doe

John Doe

John Doe

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1  
8294  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

08330  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>		c. LENGTH OF STAY IN 1b <b>2 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>5927 Berwyn Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>A</b> Last <b>JONES</b>		4. DATE OF DEATH Month <b>July</b> Day <b>6</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 8, 1887</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR: Months <b>7</b> Days <b>19</b> Hours <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>North Carolina</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James E. Jones</b>		14. MOTHER'S MAIDEN NAME <b>Edie UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-03-0756</b>	
17. INFORMANT <b>Alice J Jones (Wife)</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO <b>332X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>CEREBROVASCULAR THROMBOSES</b> (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>3 MONTHS</b> <b>YEARS (?)</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MAY</b> , 19 <b>60</b> , to <b>5 JULY</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>5 JULY</b> , 19 <b>60</b> , and that death occurred at <b>5 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>405 SHERIDAN, HYATTSVILLE</b> DATE SIGNED <b>7/6/60</b> ACTUAL SIGNATURE <b>Henry R. Wolfe</b> M.D. PHYSICIAN'S NAME (Type) <b>Henry R Wolfe</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-8-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>H. Lincoln Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Bladensburg Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co. Burial &amp; Crem.</b>		24a. REC'D BY REGISTRAR DATE <b>Jul 8 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			





may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

8390

08331

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>				c. LENGTH OF STAY IN 1b. <b>1 month and 23 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenn Dale Hospital</b>				d. STREET ADDRESS <b>1840 L. St., N. E.</b>			
3. NAME OF DECEASED (Type or print) First <b>May</b> Middle <b>-</b> Last <b>Jones</b>				4. DATE OF DEATH Month <b>7</b> Day <b>11</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/30/00</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b>		IF UNDER 24 HRS. Hours <b>-</b> Min. <b>-</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Richard Neely</b>				14. MOTHER'S MAIDEN NAME <b>Maggie Banks</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic adenocarcinoma, generalized, primary</b> DUE TO <b>site, left breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>-</b> (c) <b>-</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary tuberculosis, minimal, probably inactive; left radical mastectomy, 3/59</b>							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>102X</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/18</b> to <b>7/11</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>7/11</b> , 19 <b>60</b> , and that death occurred at <b>11</b> A. M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Moe Weiss</b>		22b. DATE SIGNED <b>7/11/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>July 12, 60</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Mem. Park</b>		23d. LOCATION (City, town, or county) (State) <b>Sherriff Road, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hall Bros</b>		ADDRESS <b>1021 Florida Ave</b>		25a. REC'D BY REGISTRAR <b>AUG 14 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

CERTIFICATE OF DEATH

8330



From this house  
1910

1910

1910

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1910

1910

1910

8366

## CERTIFICATE OF DEATH

08332

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Geo.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairmount Hghts</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairmount Heights</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>605-Eastern Ave.</u>		d. STREET ADDRESS <u>605-Eastern Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Thaddeus Jones</u>		4. DATE OF DEATH <u>July 5</u> 19 <u>60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR <u>87</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handy Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home &amp; Yards</u>	
11. BIRTHPLACE (State or foreign country) <u>S. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Jones</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Alexander Criswell</u>		Address <u>1474 Chapin St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>Hypertensive Cardio-Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>6 yrs.</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Natural Causes &amp; Age</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1948</u> , 19 <u>  </u> to <u>July 5</u> , 19 <u>60</u> that I last saw the deceased alive on <u>6-30</u> , 19 <u>60</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John W. Robinson</u> M.D.		ADDRESS (Street, city or town, state) <u>1001 Eastern Ave. N.E.</u> DATE SIGNED <u>7/5/60</u>	
PHYSICIAN'S NAME (Type) <u>John W. Robinson, M.D.</u>		<u>Washington 27, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>7-9-60</u>		22b. DATE THEREOF <u>7-9-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Nat Harmony Park</u>		22d. LOCATION (City, town, or county) (State) <u>Shuff Rd Ept Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington</u>		ADDRESS <u>4925 Deane Ave NE</u>	
24a. REC'D BY REGISTRAR <u>JUL 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1  
FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/39

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8338

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08333

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>Dead on arrival</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>District Heights</b> d. STREET ADDRESS <b>7604 Atwood St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <b>DAVID THOMAS KEILL</b>		<b>4. DATE OF DEATH</b> <b>July 17 19 60</b>		<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>May 21, 1960</b> <b>9. AGE</b> (In years last birthday) <b>1</b> <b>23</b> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Child</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Mitchell Keill</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Nancy Grant</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>None</b> <b>17. INFORMANT</b> <b>Father Mitchell Keill</b> <b>Address</b> <b>Same as #2</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO (b) <b>Smothering in bed clothing</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
<b>20a. EXTERNAL CAUSE WAS PRIMARY CAUSE OF DEATH</b> <input checked="" type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Got head wrapped in blanket</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20c. TIME OF INJURY</b> <b>7:15 a.m. 7/17/60</b> <b>20d. INJURY OCCURRED</b> <b>While at work</b> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Home</b> <b>20f. (City or town)</b> <b>District Hts</b> <b>(County)</b> <b>P.G.</b> <b>(State)</b> <b>Md.</b>		<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> <b>Natural causes</b> <input type="checkbox"/> <b>Accident</b> <input checked="" type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <i>James I. Boyd</i> <b>EXAMINER'S NAME (Type)</b> <b>James I. Boyd, M.D.</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <b>July 17, 1960</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>22b. DATE THEREOF</b> <b>7-20-1960</b> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b> <b>22d. LOCATION (City, town, or country)</b> <b>Arlington, Virginia</b>		<b>23. FUNERAL DIRECTOR</b> <b>W.W. Chambers Co. Riverdale, Md</b> <b>24a. REC'D BY REGISTRAR</b> <b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kline</i>			

2250263xv2

Prince George's General Hospital  
 7004 Atwood St.  
 District Health  
 Maryland  
 Prince George's  
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 July 17  
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 X  
 Male  
 White  
 May 21, 1960  
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 27  
 N.B.A.  
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 None  
 Maryland  
 Nancy Grant  
 Father  
 Mitchell Kell  
 Same as #2  
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 Anaphylaxis  
 Emothering in bed clothing  
 Got head wrapped in blankets  
 7/17/60  
 X  
 Home  
 District Hqs. P.G. Md.  
 X  
 X  
 X  
 X  
 James L. Boyd, M.D.  
 July 17, 1960  
 X

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

8339

08334

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly Md</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>40 Bladensburg</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Laura</b> Middle <b>Belle</b> Last <b>Kelly</b>				4. DATE OF DEATH Month <b>July</b> Day <b>10</b> Year <b>1960</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 4, 1881</b>			
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min.		IF UNDER 24 HRS. Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>									
13. FATHER'S NAME <b>James Weddell</b>				14. MOTHER'S MAIDEN NAME <b>Lydia Montgomery</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO.					
17. INFORMANT <b>Wilford W Kelly</b>				Address <b>Pittsburg, Pa</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <i>coronary arteriosclerosis</i> DUE TO (b) <i>hypertensive cardiovascular disease</i> DUE TO (c) <i>old</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>hypertensive disease</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <b>Jan</b> Day <b>19</b> Year <b>1960</b> Hour <b>a. m.</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <b>West Newton</b>				20g. (County) <b>West Newton</b>		20h. (State) <b>Pa</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1918</b> to <b>July 10, 1960</b> , that (I) (we) last saw the deceased alive on <b>July 7, 1960</b> , and that death occurred at <b>7:40 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <i>Teil Bergmann</i>				22b. DATE SIGNED <b>July 11, 1960</b>					
22c. PHYSICIAN'S NAME (Type) <b>Dr. Teil Bergmann., M.D.</b>				22d. ADDRESS <b>4314 Fallbrook Heights Rd. D</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/13/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>West Newton</b>		23d. LOCATION (City, town, or county) (State) <b>West Newton Pa</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Busch Sons Hyattsville Md</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 11 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

2510

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

8391

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

08335

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN 1b <b>16 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		d. STREET ADDRESS <b>526 First St., N. W.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenn Dale Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Raymond</b> Middle <b>M.</b> Last <b>Kinsey</b>				<b>4. DATE OF DEATH</b> Month <b>7</b> Day <b>6</b> Year <b>1960</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>9/16/03</b>	
<b>9. AGE</b> (In years lost birthday) <b>56</b> yrs.		<b>10. AGE</b> (In years lost birthday) <b>56</b> yrs.		<b>11. AGE</b> (In years lost birthday) <b>56</b> yrs.		<b>12. AGE</b> (In years lost birthday) <b>56</b> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>= Truck helper</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Men's Social Service Center, Salvation Army</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Virginia</b>	
<b>13. FATHER'S NAME</b> <b>William Kinsey</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Elzora Weaver</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>578-10-5591</b>		<b>17. INFORMANT</b> <b>Decedent</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic carcinoma with metastases to pre-aortic nodes, kidneys, adrenals, and epicardium</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Unknown</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Bilateral thrombophlebitis, lower extremities</b>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>6/20/1960</b> <b>to</b> <b>7/6/1960</b> , that (I) (we) last saw the deceased alive on <b>7/6/1960</b> , and that death occurred at <b>10:55 A.M.</b> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>Moe Weiss</b>				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input checked="" type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>7/6/60</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Moe Weiss, M. D.</b>				<b>22d. ADDRESS</b> <b>Glenn Dale Hospital</b> <b>Glenn Dale, Md.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>7/9/60</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Fairview</b>		<b>23d. LOCATION (City, town, or county)</b> <b>Culpeper Va</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>[Signature]</b>				<b>25a. REC'D BY REGISTRAR</b> <b>[Signature]</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>[Signature]</b>	
<b>25c. DATE</b> <b>JUL 11 '60</b>				<b>25d. DATE</b> <b>JUL 11 '60</b>			



CERTIFICATE OF DEATH

1900

1st of Jan (1900)

John and Mary

1st of Jan

1st of Jan

1st of Jan

1st of Jan

1st of Jan

1st of Jan

1st of Jan

1st of Jan

1st of Jan

1st of Jan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08336

8340

Item 16 Film 268 B-8-60 et

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>1 Month</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. STREET ADDRESS <b>4604 Bromley Ave.</b>	
4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>19 60</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Peter</b> Middle <b>J</b> Last <b>Knitter</b>		9. AGE (In years last birthday) <b>67</b> yrs.	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 11, 1893</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Good Will Ind.</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-05-3752</b>	
17. INFORMANT <b>Mrs. Eva M. Knitter</b>		Address <b>Same as # 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>731X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiac failure</b> DUE TO (c) <b>Poget's disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>6 months</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/28</b> 19 <b>60</b> to <b>July 29</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>July 29</b> 19 <b>60</b> , and that death occurred at <b>12:45 P. M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>E. James Shuck</b>		22b. DATE SIGNED <b>7/29/60</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>6607 Riverdale Rd. Riverdale, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 1st 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Washington National Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Bros</b>		25a. REC'D BY REGISTRAR <b>1601 Good Hope Rd. SE, Wash DC</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>		DATE <b>AUG 1 '60</b>	



8367

CERTIFICATE OF DEATH

08337

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>SAME</u> b. COUNTY <u>PRINCE GEO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>				c. LENGTH OF STAY IN TB <u>7 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>911 NICHOLS DRIVE</u>				d. STREET ADDRESS <u>911 NICHOLS DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>A</u> Last <u>LAMBERTON</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>24</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 23, 1896</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHIEF ELECTRICIAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>US NAVY</u>		11. BIRTHPLACE (State or foreign country) <u>MINNESOTA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>KELLEY LAMBERTON</u>				14. MOTHER'S MAIDEN NAME <u>ANNA WEISENBERGER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>1923 - INDEFINITE</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>HELEN LAMBERTON - WIFE - SAME ADDRESS</u>				Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORDINARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROSIS</u> DUE TO <u>  </u> (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>SECONDS</u> <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>							
21. I certify that I attended the deceased from <u>Feb 6</u> , 19 <u>58</u> , to <u>PRESENT</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>JULY 13</u> , 19 <u>60</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>402 Main St - Laurel Md.</u> DATE SIGNED <u>7/24/60</u>							
ACTUAL SIGNATURE <u>John R. Buell</u>				M.D. <u>  </u>			
PHYSICIAN'S NAME (Type) <u>  </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/28/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Redar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Stuartland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co Inc</u> ADDRESS <u>Riverdale Md</u>				24a. REC'D BY REGISTRAR <u>  </u> DATE <u>JUL 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Clifford S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

It actually belongs to my doctor at Bethesda. I was hospitalized last night was 7/18/60 at Wesley, Md.

B.P.





8392

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF Hospital Andrews Air Force Base</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>William</b> Middle <b>Andrew</b> Last <b>Link</b>		4. DATE OF DEATH		Month <b>July</b> Day <b>2</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasion</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 25 1931</b>	9. AGE (In years last birthday) <b>28</b> yrs.	IF UNDER 1 YEAR Months <b>28</b> Days <b>28</b> Hours <b>28</b> Min.	IF UNDER 24 HRS. Months <b>28</b> Days <b>28</b> Hours <b>28</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done) <b>Heavy Equipment Operator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>				13. FATHER'S NAME <b>Charles Omer Link (Deceased)</b>			
14. MOTHER'S MAIDEN NAME <b>Vonnie Lake Niday</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>Korean War</b>			
16. SOCIAL SECURITY NO. <b>227-36-3882</b>				INFORMANT <b>D.W. Kinney CWO</b> Address <b>AOD USAF Hospital Andrews</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Electric Shock</b> 714.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Unknown</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>with bare wire.</b> <b>While working on plumbing underneath trailer he came in contact</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>Jul 2 1960</b> 11:30 a. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, street, office bldg., etc.) <b>House Trailer</b>	20f. (City or town) <b>Upper Marlboro</b>	(County) <b>P.G.</b>	(State) <b>Md.</b>		
21. I certify that I attended the deceased from <b>July 2</b> , 19 <b>60</b> , to <b>2 July</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Never seen</b> , 19 <b>60</b> , and that death occurred at <b>1210 P. M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Thomas D B Fennell</b>				ADDRESS (Street, city or town, state) <b>USAF Hospital Andrews</b>		DATE SIGNED <b>2 July 1960</b>	
PHYSICIAN'S NAME (Type) <b>THOMAS D B FENNELL</b>				<b>Washington 25, D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/5/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hoges Store Cemetery</b>	22d. LOCATION (City, town, or county) <b>Hoges Store</b>	(State) <b>Virginia</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Kinna</b>		ADDRESS <b>Upper Marlboro, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 11 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinna</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

De la Cruz et al.

*(continued)*

1505-2007

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8341

Item 3, Film G-269 8/30/60.cac.

08339

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>2 da.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Robert</b> First <b>William</b> Middle <b>Loveless</b> Last <b>Baby Boy</b>				4. DATE OF DEATH Month <b>July</b> Day <b>5</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-3-60</b>	
9. AGE (In years lost birthday) <b>2 Da.</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>Philip Andrew Loveless</b>				14. MOTHER'S MAIDEN NAME <b>Kathryn Ruth Jefferies</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mother Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fetal Atelectasis</b> <b>762.5</b> DUE TO <b>Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>July 3</b> <b>1960</b> to <b>July 5</b> <b>1960</b> that (I) (we) lost saw the deceased alive on <b>July 5</b> <b>1960</b> , and that death occurred at <b>4:50 pm</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. George Hagegele</b>				22b. DATE <b>July 6/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. George Hagegele, M.D.</b>				22d. ADDRESS <b>3717 38th Ave. Cottage City, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>7/7/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	
23d. LOCATION (City, town, or county) <b>Colmar Manor, Md.</b>				23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				24b. ADDRESS <b>Hyattsville, Md.</b>			
25a. REC'D BY REGISTRAR <b>JUL 8 '60</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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105230

OFFICE OF THE

105230



TO THE DIRECTOR, FBI  
FROM THE DIRECTOR, FBI  
SUBJECT: [Illegible]  
[The following text is extremely faint and largely illegible, appearing to be a memorandum or report. It contains several lines of text, some of which may be names or titles, but they cannot be accurately transcribed.]



8393

## CERTIFICATE OF DEATH

08340

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS (RURAL)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS (RURAL)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL ANDREWS</b>		d. STREET ADDRESS <b>6968 ALLENTOWN ROAD</b>	
3. NAME OF DECEASED (Type or print) First <b>MARTIN</b> Middle <b>N/B</b> Last <b>MALE</b>		4. DATE OF DEATH Month <b>July</b> Day <b>7</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUC.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5 July 1960</b>
9. AGE (In years last birthday) yrs. <b>1</b> Months <b>6</b> Days <b>45</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>LEWIS G MARTIN</b>		14. MOTHER'S MAIDEN NAME <b>BETTY L. (MARTIN) FARLEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>FATHER</b>		Address <b>SAME AS #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Anoxia</b> <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prematurity</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 HRS</b> <b>30 HRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5 July</b> , 19 <b>60</b> , to <b>7 July</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>7 July</b> , 19 <b>60</b> , and that death occurred at <b>0125 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Arnold A. Abramo</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>USAF Hq. Andrews AFB 7 July 60</b>	
PHYSICIAN'S NAME (Type) <b>ARNOLD A. ABRAMO, CAPT USAF MC</b>		<b>ANDREWS AFB, WASH 25, D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/11/60</b>	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) <b>Fredericktown, Ohio</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rinaldi</b>		ADDRESS <b>Rinaldi Funeral Home, Inc. 816 H St., NE, Wash. 2, DC</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 11 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2050265XV1



00350

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male	
3. AGE 35		4. DATE OF BIRTH 12-1-29	
5. PLACE OF BIRTH MOBILE, ALABAMA		6. OCCUPATION None	
7. MARITAL STATUS Single		8. COLOR White	
9. EDUCATION High School		10. RELIGION None	
11. PRESENT ADDRESS Room 107, 400 N. Salisbury St., Baltimore, Md.		12. DATE OF DEATH 4-4-68	
13. CAUSE OF DEATH Suicide by gunshot		14. PLACE OF DEATH Room 107, 400 N. Salisbury St., Baltimore, Md.	
15. SIGNATURE OF PHYSICIAN J. Edgar Hoover		16. SIGNATURE OF DEATH CERTIFICATE OFFICER J. Edgar Hoover	
17. SIGNATURE OF WITNESSES J. Edgar Hoover		18. SIGNATURE OF CORONER J. Edgar Hoover	
19. SIGNATURE OF JURY J. Edgar Hoover		20. SIGNATURE OF JUDGE J. Edgar Hoover	
21. SIGNATURE OF DISTRICT ATTORNEY J. Edgar Hoover		22. SIGNATURE OF CLERK J. Edgar Hoover	
23. SIGNATURE OF SHERIFF J. Edgar Hoover		24. SIGNATURE OF JAILER J. Edgar Hoover	
25. SIGNATURE OF PRISON WARDEN J. Edgar Hoover		26. SIGNATURE OF PRISON CHIEF J. Edgar Hoover	
27. SIGNATURE OF PRISON CLERK J. Edgar Hoover		28. SIGNATURE OF PRISON JAILER J. Edgar Hoover	
29. SIGNATURE OF PRISON WARDEN J. Edgar Hoover		30. SIGNATURE OF PRISON CHIEF J. Edgar Hoover	
31. SIGNATURE OF PRISON CLERK J. Edgar Hoover		32. SIGNATURE OF PRISON JAILER J. Edgar Hoover	
33. SIGNATURE OF PRISON WARDEN J. Edgar Hoover		34. SIGNATURE OF PRISON CHIEF J. Edgar Hoover	
35. SIGNATURE OF PRISON CLERK J. Edgar Hoover		36. SIGNATURE OF PRISON JAILER J. Edgar Hoover	
37. SIGNATURE OF PRISON WARDEN J. Edgar Hoover		38. SIGNATURE OF PRISON CHIEF J. Edgar Hoover	
39. SIGNATURE OF PRISON CLERK J. Edgar Hoover		40. SIGNATURE OF PRISON JAILER J. Edgar Hoover	
41. SIGNATURE OF PRISON WARDEN J. Edgar Hoover		42. SIGNATURE OF PRISON CHIEF J. Edgar Hoover	
43. SIGNATURE OF PRISON CLERK J. Edgar Hoover		44. SIGNATURE OF PRISON JAILER J. Edgar Hoover	
45. SIGNATURE OF PRISON WARDEN J. Edgar Hoover		46. SIGNATURE OF PRISON CHIEF J. Edgar Hoover	
47. SIGNATURE OF PRISON CLERK J. Edgar Hoover		48. SIGNATURE OF PRISON JAILER J. Edgar Hoover	
49. SIGNATURE OF PRISON WARDEN J. Edgar Hoover		50. SIGNATURE OF PRISON CHIEF J. Edgar Hoover	
51. SIGNATURE OF PRISON CLERK J. Edgar Hoover		52. SIGNATURE OF PRISON JAILER J. Edgar Hoover	
53. SIGNATURE OF PRISON WARDEN J. Edgar Hoover		54. SIGNATURE OF PRISON CHIEF J. Edgar Hoover	
55. SIGNATURE OF PRISON CLERK J. Edgar Hoover		56. SIGNATURE OF PRISON JAILER J. Edgar Hoover	
57. SIGNATURE OF PRISON WARDEN J. Edgar Hoover		58. SIGNATURE OF PRISON CHIEF J. Edgar Hoover	
59. SIGNATURE OF PRISON CLERK J. Edgar Hoover		60. SIGNATURE OF PRISON JAILER J. Edgar Hoover	
61. SIGNATURE OF PRISON WARDEN J. Edgar Hoover		62. SIGNATURE OF PRISON CHIEF J. Edgar Hoover	
63. SIGNATURE OF PRISON CLERK J. Edgar Hoover		64. SIGNATURE OF PRISON JAILER J. Edgar Hoover	
65. SIGNATURE OF PRISON WARDEN J. Edgar Hoover		66. SIGNATURE OF PRISON CHIEF J. Edgar Hoover	
67. SIGNATURE OF PRISON CLERK J. Edgar Hoover		68. SIGNATURE OF PRISON JAILER J. Edgar Hoover	
69. SIGNATURE OF PRISON WARDEN J. Edgar Hoover		70. SIGNATURE OF PRISON CHIEF J. Edgar Hoover	
71. SIGNATURE OF PRISON CLERK J. Edgar Hoover		72. SIGNATURE OF PRISON JAILER J. Edgar Hoover	
73. SIGNATURE OF PRISON WARDEN J. Edgar Hoover		74. SIGNATURE OF PRISON CHIEF J. Edgar Hoover	
75. SIGNATURE OF PRISON CLERK J. Edgar Hoover		76. SIGNATURE OF PRISON JAILER J. Edgar Hoover	
77. SIGNATURE OF PRISON WARDEN J. Edgar Hoover		78. SIGNATURE OF PRISON CHIEF J. Edgar Hoover	
79. SIGNATURE OF PRISON CLERK J. Edgar Hoover		80. SIGNATURE OF PRISON JAILER J. Edgar Hoover	
81. SIGNATURE OF PRISON WARDEN J. Edgar Hoover		82. SIGNATURE OF PRISON CHIEF J. Edgar Hoover	
83. SIGNATURE OF PRISON CLERK J. Edgar Hoover		84. SIGNATURE OF PRISON JAILER J. Edgar Hoover	
85. SIGNATURE OF PRISON WARDEN J. Edgar Hoover		86. SIGNATURE OF PRISON CHIEF J. Edgar Hoover	
87. SIGNATURE OF PRISON CLERK J. Edgar Hoover		88. SIGNATURE OF PRISON JAILER J. Edgar Hoover	
89. SIGNATURE OF PRISON WARDEN J. Edgar Hoover		90. SIGNATURE OF PRISON CHIEF J. Edgar Hoover	
91. SIGNATURE OF PRISON CLERK J. Edgar Hoover		92. SIGNATURE OF PRISON JAILER J. Edgar Hoover	
93. SIGNATURE OF PRISON WARDEN J. Edgar Hoover		94. SIGNATURE OF PRISON CHIEF J. Edgar Hoover	
95. SIGNATURE OF PRISON CLERK J. Edgar Hoover		96. SIGNATURE OF PRISON JAILER J. Edgar Hoover	
97. SIGNATURE OF PRISON WARDEN J. Edgar Hoover		98. SIGNATURE OF PRISON CHIEF J. Edgar Hoover	
99. SIGNATURE OF PRISON CLERK J. Edgar Hoover		100. SIGNATURE OF PRISON JAILER J. Edgar Hoover	

14

TO THE DIRECTOR OF THE MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

8342

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08341

Item 2 Film 267 1-28-60 et

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Maryland</b> c. LENGTH OF STAY IN 1b <b>6 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Maryland Falls Church</b> d. STREET ADDRESS <b>1905 Dye Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>E.</b> Last <b>McCarthy</b>		4. DATE OF DEATH Month <b>July</b> Day <b>17</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 30, 1882</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Troy, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Michael Flaherty</b>		14. MOTHER'S MAIDEN NAME <b>Helena Hickey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT Address <b>Mrs. Rita Roache, 3839- Hamilton St. Hyattsville Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Confluent Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Thrombosis (right fronto-parietal)</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b> <b>1 week</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12 Jul 1960</b> to <b>17 Jul 1960</b> that (I) (we) last saw the deceased alive on <b>17 Jul 1960</b> and that death occurred <b>5:35 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas G. Maloney</b>		22b. DATE SIGNED <b>17 Jul 60</b>	
22c. PHYSICIAN'S NAME (Type) <b>THOMAS G. MALONEY</b>		22d. ADDRESS <b>4814-71st Ave. Lanham Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 21/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Washington National Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Brothers</b>		25a. REC'D BY REGISTRAR <b>1661- 688d Hope Rd. S.E. Washington 20, D.C.</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		DATE <b>JUL 20 '60</b>	

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## CERTIFICATE OF DEATH

08342

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pro Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville Md</b>		c. LENGTH OF STAY IN 1b <b>57 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3807 Oglethrope St</b>		d. STREET ADDRESS <b>3807 Oglethrope St</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Cora</b> Middle <b>L</b> Last <b>Mc Clay</b>		4. DATE OF DEATH Month <b>July</b> Day <b>1</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 7, 1893</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>E O Little</b>		14. MOTHER'S MAIDEN NAME <b>Hallie Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
INFORMANT <b>Henry E Mc Clay</b>		Address <b>Hyattsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulatory Pancreas.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ b. _____ c. _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>no</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>4:30</b> PM <b>7/1/60</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 18</b> , 19 <b>60</b> to <b>July 1</b> , 19 <b>60</b> and that death occurred at <b>11:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1746 K St. N.W. Wash DC</b> DATE SIGNED _____ ACTUAL SIGNATURE <b>Dr. Irving Brotman</b> M.D. PHYSICIAN'S NAME (Type) <b>DR. IRVING BROTMAN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/5/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St John's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Beltville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 6 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND												2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -																																			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)												c. LENGTH OF STAY IN 1b 1 day												c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington																							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital												d. STREET ADDRESS 1406 15th St., N. W.												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) First Benny Middle - Last McCullough												4. DATE OF DEATH Month 7 Day 6 Year 1960																																			
5. SEX Male				6. COLOR OR RACE Negro				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 6/15/1918				9. AGE (In years last birthday) 42 yrs.				IF UNDER 1 YEAR Months Days Hours Min.				IF UNDER 24 HRS. Months Days Hours Min.																							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown												10b. KIND OF BUSINESS OR INDUSTRY Unknown												11. BIRTHPLACE (State or foreign country) S. Carolina												12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME Unknown												14. MOTHER'S MAIDEN NAME Unknown																																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown												16. SOCIAL SECURITY NO. Unknown												17. INFORMANT Chest Clinic (Too ill to give information) (on admission)																							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardioma of the lungs, primary site undetermined, pulmonary tuberculosis, far advanced, active 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												INTERVAL BETWEEN ONSET AND DEATH Unknown																																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																																			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19												20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>												20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)												20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 7/6/1960 to 7/6/1960, that (I) (we) last saw the deceased alive on 7/6/1960, and that death occurred at P. M. from the causes and on the date stated above.												22a. SIGNATURE Moe Weiss												22b. DATE SIGNED 7/6/60																							
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.												22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.																																			
23a. BURIAL, CREMATION, REMOVAL (Specify)												23b. DATE THEREOF 7/9/60												23c. NAME OF CEMETERY OR CREMATORY New Harmony												23d. LOCATION (City, town, or county) (State) Md											
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 1121-10th St. CORNISH + CORNISH + SON, INC.												25a. REC'D BY REGISTRAR DATE JUL 11 '60												25b. REGISTRAR'S SIGNATURE Arthur S. Kraus																							

98343

CERTIFICATE OF DEATH

NAME

AGE

SEX

DATE

TIME

PLACE

CAUSE

MANNER

REPORTER

SIGNATURE

DATE

PLACE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8395

## CERTIFICATE OF DEATH

08344

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN 1b 7 MONTHS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BLDG 1-86, ANDREWS AFB, WASH 25, DC		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES PAUL MC GRATH		4. DATE OF DEATH Month Day Year JULY 19 19 60	
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 MAY 1913
9. AGE (In years lost birthday) 47 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AIRMAN		10b. KIND OF BUSINESS OR INDUSTRY US AIR FORCE	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME JAMES MC GRATH		14. MOTHER'S MAIDEN NAME MARY DEVINE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> (If yes, give war or dates of service) 1940 - 1960		16. SOCIAL SECURITY NO. INFORMANT Address PERSONNEL OFFICER HQ ARDC, ANDREWS AFB	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE, ATHEROMATOUS PLAQUE RIGHT CORONARY ARTERY DOA 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 JULY, 1960, to 19 JULY, 1960, that I last saw the deceased alive on 19 JULY, 1960, and that death occurred at 11:32 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE David N Robb		ADDRESS (Street, city or town, state) DATE SIGNED USAF HOSPITAL ANDREWS 19 JULY 60	
PHYSICIAN'S NAME (Type) DAVID N ROBB, CAPT USAF (MC)		ANDREWS AIR FORCE BASE, WASHINGTON 25, DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 23, 1960	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) JENKINTOWN, PA.	
23. FUNERAL DIRECTOR'S SIGNATURE RINALDI FUNERAL HOME 816 H ST. N.E. WASH DC		24a. REC'D BY REGISTRAR DATE JUL 21 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

113343

CERTIFICATE OF DEATH

113343



Blank form with horizontal lines for text entry.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE BOARD OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
08345

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>11 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover Hills</b> d. STREET ADDRESS <b>7226 Glenridge Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Harold</b> First <b>L</b> Middle <b>McKenna</b> Last		4. DATE OF DEATH <b>July</b> Month <b>27</b> Day <b>1960</b> Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 1, 1903</b>
9. AGE (In years lost birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>	
11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John F. McKenna</b>		14. MOTHER'S MAIDEN NAME <b>Harriet Fulford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>181039504</b>	
17. INFORMANT <b>Bertha M. McKenna (Wife)</b> Address <b>Same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260X</b> DUE TO <b>diabetic acidosis disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Hepatic failure</b> DUE TO (c) <b>Portal cirrhosis</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between onset and death</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 30 8:30 A.M.</b> to <b>July 27 1960</b> that (I) (we) last saw the deceased alive on <b>July 26, 1960</b> and that death occurred at <b>M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>William D. Rosson M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM D. ROSSON, M.D.</b>		22d. ADDRESS <b>5304 Annapolis Rd, Bladensburg, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/29/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Ceme.</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Maryland</b>		25a. REC'D BY REGISTRAR <b>AUG 1 '60</b> DATE	
		25b. REGISTRAR'S SIGNATURE <b>Clayton S. Kraus</b>	



08382

CENTRAL OF TEXAS

8347

Electrician

John F. Johnson

181030304

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VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

8344

08346

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <del>ANNAPOLIS</del> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly Md</b>		c. LENGTH OF STAY IN 1b <b>1 month 2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt, 67</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				d. STREET ADDRESS <b>9 D Southway Rd</b>			
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>McLoughlin</b> Last <b>McLoughlin</b>				4. DATE OF DEATH Month <b>7/</b> Day <b>18/</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/31/91</b>	
9. AGE (In years lost birthday) <b>69</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John Hickey</b>				14. MOTHER'S MAIDEN NAME <b>? Moran</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Hospital records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>153.8</b> IMMEDIATE CAUSE (a) <b>Carcinoma of Colon</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Secondary anemia</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>16 Jun. 1960</b> to <b>18 Jul 1960</b> that (I) (we) last saw the deceased alive on <b>18 Jul 1960</b> and that death occurred at <b>4:40 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Thomas G. Maloney</b>				22b. ADDRESS <b>4814 - 71st Ave. Landover Hills Md.</b>		22c. PHYSICIAN'S NAME (Type) <b>THOMAS G. MALONEY</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 21, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville Md.</b>				25a. REC'D BY REGISTRAR <b>JUL 22 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

(M)

077

(1)

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1

08340

0844

CERTIFICATE OF DEATH

STATE OF NEW YORK

IN SENATE

191

1. Name of deceased

2. Date of death

3. Place of death

4. Cause of death

5. Name of physician

6. Name of funeral director

7. Name of undertaker

1

8. Name of registrar

9. Name of witness

10. Name of witness

11. Name of witness

12. Name of witness

13. Name of witness

14. Name of witness

15. Name of witness

16. Name of witness

17. Name of witness

18. Name of witness

19. Name of witness

20. Name of witness

8396 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 CERTIFICATE OF DEATH

Reg. Dist. No. 08347

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berkshire	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home		d. STREET ADDRESS 3900 75th Ave. S.E.	
3. NAME OF DECEASED (Type or print) First DUNCAN Middle G. Last McPHERSON		4. DATE OF DEATH Month July Day 23rd Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 10 1874
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Carpenter	
11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Donald McPherson		14. MOTHER'S MAIDEN NAME Catherine McDougall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) I		16. SOCIAL SECURITY NO. INFORMANT Address Wilbur E. McPherson 3900 75th Ave S.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Ac. Coronary Thrombosis (b) Generalized Arteriosclerosis (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Similarity 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 to July 23, 1960 that I last saw the deceased alive on Jan 1960, and that death occurred at 8:40 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Bernard Katzen M.D. 3550 Minn. Ave. S.E. Wash DC 7-23-60 PHYSICIAN'S NAME (Type) Dr. Bernard Katzen 3550 Minn. Ave. S. E. Washington, D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-26-1960	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

REC'D BY REGISTRAR  
 JUL 25 '60  
 DATE

*[Faint handwritten notes at the bottom of the page, possibly "P. A. 1000 HIKED"]*

1001-0000 HIRSH



8303

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HYATTSVILLE CONVALESCENT + REST HOME</u>				d. STREET ADDRESS <u>14711 NORWICH RD.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM SIMON MILLS</u>				4. DATE OF DEATH Month Day Year <u>JULY 30 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 17-1880</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. (AIRCRAFT)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AIRCRAFT</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>UNKNOWN</u>			
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>UNKNOWN</u>				17. INFORMANT <u>daughter</u> Address <u>MILDRED B. SCHULTE-9015 Adelphi Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROSIS - GENERALIZED</u> DUE TO <u>SEVERE</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTHRITIS + CACNOXIA</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u> <u>-10 YRS.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>OCT 15 1956</u> , to <u>JULY 30 1960</u> , that I last saw the deceased alive on <u>JULY 28 1960</u> , and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David Sterling</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>352 UNIVERSITY BLVD</u>			
PHYSICIAN'S NAME (Type) <u>HAROLD STERLING MD</u>				<u>HYATTSVILLE MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8/2/60</u>		<u>Fort Lincoln</u>		<u>Bladensburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. Chambers Co Riverdale Md</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 3 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

Chambers Funeral director - Riverdale, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

08349

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>7 1/2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial Hospital.</u>				d. STREET ADDRESS <u>15704 64th. Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Victor</u> Middle <u>Mindeleft</u> Last <u>Mindeleft</u>				4. DATE OF DEATH Month <u>7</u> Day <u>6</u> Year <u>60</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-9-1886</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sanitary Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dist. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Victor Mindeleft, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Jesse L. Randall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>  </u>				16. SOCIAL SECURITY NO. <u>  </u>			
17. INFORMANT (Wife) <u>Mrs. Evelyn C. Mindeleft</u>				Address <u>5704-64th. Ave. Riverdale, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myelogenous Leukemia</u> <u>204.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>60</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>6-29</u> , 19 <u>60</u> , to <u>7-6</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7-5</u> , 19 <u>60</u> , and that death occurred at <u>1:20 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L W Malin</u> M.D.				ADDRESS (Street, city or town, state) <u>Riverdale Md.</u>			
DATE SIGNED <u>7-6-60</u>							
PHYSICIAN'S NAME (Type) <u>L W Malin M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>7-9-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematorium</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home NE DC</u>				ADDRESS <u>300-4 ST.</u>		24a. REC'D BY REGISTRAR <u>  </u>	
DATE <u>Jul 11 '60</u>				24b. REGISTRAR'S SIGNATURE <u>  </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08350

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) o. STATE Virginia b. COUNTY Richmond City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Richmond	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 3929 Alma Avenue	
3. NAME OF DECEASED (Type or print) Jon Shelton Moroney		4. DATE OF DEATH July 17 19 60	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1938.
9. AGE (In years last birthday) 27 yrs.		10. IF UNDER 1 YEAR Months Days Hours Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Painter		10b. KIND OF BUSINESS OR INDUSTRY Cheverolet Co	
11. BIRTHPLACE (State or foreign country) Richmond Va		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John A. Moroney		14. MOTHER'S MAIDEN NAME Della Shelton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT John A Moroney		Address Richmond Virginia	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture dislocation between 2nd and 3rd cervical vertebrae and severence of spinal cord. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of a midget racing car which went out of control.	
20c. TIME OF INJURY Month, Day, Year 5:35 p. m. 7-17- 19 60		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Speedway		20f. (City or town) Vista (County) Pr. Geo. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 17, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7/18/60	
22c. NAME OF CEMETERY OR CREMATORY Richmond		22d. LOCATION (City, town, or county) (State) Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Esch's sons Hyattsville Md		24a. REC'D BY REGISTRAR DATE JUL 19 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

1. **MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

8304

08351

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEO.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>VIRGINIA</b> b. COUNTY <b>VIRGINIA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>		c. LENGTH OF STAY IN 1b <b>2 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CARROLL MANOR</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY ELIZABETH MULDOWNNEY</b>		4. DATE OF DEATH <b>July 19 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/18/94</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>VINCENT WASSELL</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH ANDERSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mrs. Calvin L. Stevens, 194 E. 6th St.</b>		Address <b>New York, N.Y.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: <b>332X</b> IMMEDIATE CAUSE (a) <b>Cerebral vascular occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arterio-sclerosis</b> DUE TO (c) <b>3-4 years</b> INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 10 1956</b> to <b>July 19 1960</b> , that (I) (we) last saw the deceased alive on <b>July 19 1960</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Frank R. Shea</b>		22b. DATE SIGNED <b>7/20/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>FRANK R. SHEA</b>		22d. ADDRESS <b>4100 - 22nd NE Wash DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL</b>		23b. DATE THEREOF <b>7/25/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARY MAGDALEN CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>HOMESTEAD, PENNSYLVANIA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b>		25a. REC'D BY REGISTRAR <b>JUL 25 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

03351

CERTIFICATE OF DEATH

3304

ATTEST

THIS 15th DAY OF

1915

ATTEST

DEPUTY CLERK

WITNESSES

ATTEST

DEPUTY CLERK

DEPUTY CLERK

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1

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8368

## CERTIFICATE OF DEATH

08352

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>				c. LENGTH OF STAY IN 1b <u>5 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>211 DORSET ROAD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH Month <u>JULY</u> Day <u>14</u> Year <u>1960</u>							
3. NAME OF DECEASED (Type or print) First <u>ETNA</u> Middle <u>GLADYS</u> Last <u>NEWTON</u>		5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WH</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>MAY 16, 1901</u>		9. AGE (In years last birthday) <u>59</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ASSEMBLY</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JOHN C. NICHOLSON</u>		14. MOTHER'S MAIDEN NAME <u>NANNIE M. RAWLINGS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>579-05-8730</u>		17. INFORMANT <u>DAUGHTER - MRS FLORENCE MARION - SAME</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORDINARY OCCLUSION</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ATHEROSCLEROSIS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 HR</u> <u>YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>55</u> , to <u>July</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>JULY 14</u> , 19 <u>60</u> , and that death occurred at <u>8:05</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>John R. Buell</u> M.D. <u>402 MAIN ST LAUREL MD 7/14/60</u> PHYSICIAN'S NAME (Type) <u>JOHN R. BUELL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-16-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Potomac Church Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Fredericksburg, Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Riverdale, Ind.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove above papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **08353**

8307

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakona Park</u>		c. LENGTH OF STAY IN 1b <u>10 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1102 Kingwood Drive</u>		d. STREET ADDRESS <u>1102 Kingwood Drive</u>	
3. NAME OF DECEASED (Type or print) <u>HARRIET</u> First Middle Last		4. DATE OF DEATH <u>JULY</u> Month Day Year <u>4</u> 19 <u>60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 10, 1880</u>
9. AGE (In years lost birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>	
13. FATHER'S NAME <u>Hofmeister</u>		14. MOTHER'S MAIDEN NAME <u>Not Available</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs. Cassie Michaelis (same as #2)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO <u>163X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic CARCINOMA - Lung - Primary</u> DUE TO <u>site unknown</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> Of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MAR 17</u> , 19 <u>60</u> , to <u>JUL 4</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>JULY 4</u> , 19 <u>60</u> , and that death occurred at <u>1155A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ernest A. Sarawo</u> M.D.		ADDRESS (Street, city or town, state) <u>7006 New Hampshire Ave</u> DATE SIGNED <u>July 4, 1960</u>	
PHYSICIAN'S NAME (Type) <u>Tedsona Park, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>July 5, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll Ave</u> ADDRESS		24. REC'D BY REGISTRAR <u>Jul 6 '60</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08354

Reg. Dist. No.

8346

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>DOA</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>R.F.D. Box 1110</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Donald</b> Last <b>Norfolk</b>				4. DATE OF DEATH Month <b>July</b> Day <b>12</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-27-34</b>	
9. AGE (In years last birthday) <b>26</b> yrs.		IF UNDER 1 YEAR Months <b>26</b> Days <b>26</b> Hours <b>26</b> Min.		IF UNDER 24 HRS. Hours <b>26</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance man</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>State Roads</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Ernest Wm. Norfolk</b>				14. MOTHER'S MAIDEN NAME <b>Myrtle C. Grierson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1956-58</b>		17. INFORMANT <b>John P. Lloyd; same address as # 2.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO (b) <b>Fractured skull, crushed chest and pelvis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Struck by a motor vehicle while he was at work.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Struck by a motor vehicle while he was at work.</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Struck by a motor vehicle while he was at work.</b>					
20c. TIME OF INJURY Month, Day, Year <b>July 12 1960</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Berwyn Hts., Pr. Geo</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John T. Maloney</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/15/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Fun'l Home-Upper Marlboro, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE JUL 19 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kenna</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

88354

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John J. [illegible]		Male		[illegible]	
Date of Death		Place of Death		Cause of Death	
July 1, 1935		[illegible]		[illegible]	
Residence		Occupation		Manner of Death	
[illegible]		[illegible]		[illegible]	
Physician		Hospital		Coroner	
[illegible]		[illegible]		[illegible]	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
[illegible]		[illegible]		[illegible]	

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

(M)

1999

(I)

MEDICAL CERTIFICATION

16

2

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8347

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08355

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>Dead on arrival</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>ILL</b> b. COUNTY <b>ILL</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Warenville ILL</b> d. STREET ADDRESS <b>51X-3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>James K Papenhausen</b>			4. DATE OF DEATH <b>July 24, 1960</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Oct 13, 1937</b>		9. AGE (in years last birthday) <b>22</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <b>Canton ILL</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Herbert</b>			14. MOTHER'S MAIDEN NAME <b>Elenore Burkhart</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>Hospital Records</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO (b) <b>Fracture of the base of the skull, crushed</b> DUE TO (c) <b>chest, fracture of the left femur</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>Driver of an auto that ran off road striking fixed object</b>			
21. TIME OF INJURY <b>6:15 a.m.</b> <b>7/24, 60</b>		22. INJURY OCCURRED <b>While at work</b> <input type="checkbox"/> Not While at work <input type="checkbox"/>		23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route # 1</b>	
24. (City or town) <b>Muirkirk P. G.</b>		25. (County) <b>Md.</b>		26. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>James I. Boyd</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>James I. Boyd</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <b>July 24, 1960</b>		
Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/26/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Local</b>	
22d. LOCATION (City, town, or country) <b>Hinsdale ILL</b>		(State)			
23. FUNERAL DIRECTOR <b>W W Chambers Co</b>			ADDRESS <b>Riverside Md.</b>		
24a. REC'D BY REGISTRAR <b>JUL 28 '60</b>			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		



(M)

(1)

Prince George's

Overly

Dead on arrival

Prince George's General Hospital, Washington, D.C.

James

K

Washington

July 24

60

Male

White

Oct 15, 1937

USA

Connecticut

Elmore Park

Robert

Hospital Records

Hemorrhage and shock

Fracture of the base of the skull, crushed

chest, fracture of the left femur

Driver of an auto that ran off road striking fixed object

Mr.

Walter P. G.

Route 1

6:15 PM 7/24/60

July 24, 1960

Hindale III

Local

James I. Boyd

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **08356**

**8365**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leicester Heights</u> c. LENGTH OF STAY IN 1b <u>9 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7123- Cedar Street</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leicester Heights</u> d. STREET ADDRESS <u>7123 Cedar Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Bessie Lee Peverell</u>		<b>4. DATE OF DEATH</b> Month <u>7</u> Day <u>27</u> Year <u>1960</u>		<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Feb 27, 1886</u>		<b>9. AGE</b> (In years last birthday) <u>74</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td colspan="3">IF UNDER 1 YEAR</td> <td colspan="3">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR			IF UNDER 24 HRS.			Months	Days	Hours	Min.	Hours	Min.
IF UNDER 1 YEAR			IF UNDER 24 HRS.																						
Months	Days	Hours	Min.	Hours	Min.																				
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>													
<b>13. FATHER'S NAME</b> <u>Briscoe</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Hannie Annis</u>																			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> <u>Pearl Horton</u> Address <u>7123 Cedar St</u>																	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td colspan="2"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <u>Acute congestive heart failure</u>  <b>442X</b> DUE TO  <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b> <u>Cardiovascular renal disease</u> </td> <td rowspan="2" style="vertical-align: top;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b> </td> </tr> <tr> <td colspan="2"> <b>DUE TO (b)</b>  <b>DUE TO (c)</b> </td> </tr> </table>												<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Acute congestive heart failure</u> <b>442X</b> DUE TO <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b> <u>Cardiovascular renal disease</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	<b>DUE TO (b)</b> <b>DUE TO (c)</b>										
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Acute congestive heart failure</u> <b>442X</b> DUE TO <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b> <u>Cardiovascular renal disease</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>																							
<b>DUE TO (b)</b> <b>DUE TO (c)</b>																									
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>																									
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)																					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)																	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																									
<b>ACTUAL SIGNATURE</b> <u>James I. Boyd</u> M.D.						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			<b>DATE SIGNED</b>																
<b>EXAMINER'S NAME (Type)</b> <u>James I. Boyd</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>																
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>7-29-60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill</u>				<b>22d. LOCATION (City, town, or county)</b> (State) <u>Suitland, Md.</u>															
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Lee Funeral Home</u>						<b>ADDRESS</b> <u>Washington D.C.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>JUL 28 '60</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>															

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8348

08357

Item 9 Film 268 8-5-60 et

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>2 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Traggott</b> Last <b>Pflug</b>		4. DATE OF DEATH Month <b>July</b> Day <b>27</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 21, 1901</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Iowa</b>
13. FATHER'S NAME <b>Julius Pflug</b>		14. MOTHER'S MAIDEN NAME <b>Annette ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>525-44-4884</b>	
17. INFORMANT <b>Mrs. Frances D. Pflug,</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LOBAR PNEUMONIA - LEFT LOWER LOBE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 25</b> to <b>July 27</b> 19 <b>60</b> that (I) (we) lost saw the deceased alive on <b>July 27</b> 19 <b>60</b> , and that death occurred at <b>5:10AM</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas G. Maloney</b>		22b. DATE SIGNED <b>27 Jul 60</b>	
22c. PHYSICIAN'S NAME (Type) <b>THOMAS G. MALONEY</b>		22d. ADDRESS <b>4814-71st Ave. LANDOVER HILLS MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 29, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>3201 Bladensburg Rd., N.E., - DC</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Cherry Chase F.H.</b>		25a. REC'D BY REGISTRAR <b>AUG 1 '60</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

03323

CONTINUATION OF REPORT

03323

RESEARCHER'S NAME

DATE OF REPORT

PROJECT TITLE

REPORT NO.

DATE OF REPORT

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-23-2001 BY SP-6 JAC/STP

03 19 2001

1001, 53, 1001

10-23-2001

1001, 53, 1001

1001, 53, 1001





1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08358

1. PLACE OF DEATH a. COUNTY <b>Prince Georges General</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b. <b>15 hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		d. STREET ADDRESS <b>Westriver</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>Pinkey</b>		4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-28-60</b>
9. AGE (In years lost birthday) <b>15 yrs.</b>		10. IF UNDER 1 YEAR: Months <b>—</b> Days <b>—</b> Hours <b>15</b> Min. <b>hrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>and</b>	
11. BIRTHPLACE (State or foreign country) <b>and</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Henry /Pinkey</b>		14. MOTHER'S MAIDEN NAME <b>Alice Elizabeth Douglas</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mother</b> Address <b>Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anoxia</b> <b>754.3</b> DUE TO <b>Asphyxia</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Asphyxia</b> (c) <b>Intra atrial Septal defect</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7/28</b> 19 <b>60</b> to <b>7/28</b> 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>7/28</b> 19 <b>60</b> , and that death occurred at <b>4:15 pm</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>John W. Perkins</b>		22b. DATE SIGNED <b>7/29/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. John W. Perkins, M.D.</b>		22d. ADDRESS <b>5301 Hamilton St., Hyattsville</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>7/30/60</b>		23b. DATE THEREOF <b>7/30/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Phillips Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Aguasco</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George S. Kolson</b>		25a. REC'D BY REGISTRAR <b>Arthur S. Thomas</b>	
ADDRESS <b>Aguasco Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	
DATE <b>AUG 3 '60</b>			

2077279XV5

THE UNIVERSITY OF CHICAGO

1  
FOR STATE  
HEALTH DEPT.

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME  
SM 7/59

8397  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
8359  
MARYLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clinton</b>		c. LENGTH OF STAY IN 1b <b>Transient</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clinton</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Old Gravel Pit</b>				d. STREET ADDRESS <b>Rt. #1 Box 671</b>		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Thornton</b> Last <b>PROCTOR</b>				4. DATE OF DEATH Month <b>July</b> Day <b>13</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 March 1930</b>		9. AGE (In years last birthday) <b>30</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Oscar Proctor</b>				14. MOTHER'S MAIDEN NAME <b>Marie Richardson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>***</b>		17. INFORMANT <b>Elizabeth J Proctor (Wife) same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> 981x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gun shot wound of the head</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY (or CONTRIBUTING) CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot in the head</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Place of death Clinton P. G. Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James I. Boyd</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>7/13/60</b>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-16-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St John</b>		22d. LOCATION (City, town, or country) (State) <b>Clinton Md</b>	
23. FUNERAL DIRECTOR <b>Hunter Funeral Home, Waldorf, Md</b>				24e. REC'D BY REGISTRAR DATE <b>JUL 19 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	

MEDICAL CERTIFICATION

01330

Prince George

Marland

Prince George's

Clinton

Transit

Clinton

X

Box 671 W.A.

Old Gray 1 Pit

60

15

July

PROCTOR

Thornton

Joseph

50

26 March 1930

Male

Colored

U.S.A.

Washington, D.C.

Construction

Laborer

Marion Richardson

John Oscar Proctor

Elizabeth J Proctor (Wife) same as 2

No

Remortgage and check

Gun shot wound of the head

Shot in the head

Place of death Clinton P. D.

X

X

X

X

11/17/60

James L. Boyd

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

8350

08360

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. LENGTH OF STAY IN 1b <u>10 Hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				d. STREET ADDRESS <u>5602 Rhode Island</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>Queen</u> Last <u>Queen</u>				4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>19 60</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-28-85</u>	
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min.		IF UNDER 24 HRS. Hours <u>7</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Horane Beverly</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Gardner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Carrie E. Brown</u>		Address <u>Step-daughter</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Obstruction</u> DUE TO <u>570.4</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fecal Impaction</u> DUE TO <u>570.4</u> (c) <u>570.4</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>570.4</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>60</u> to <u>July 6</u> 19 <u>60</u> , that (I) (we) lost saw the deceased alive on <u>July 6</u> 19 <u>60</u> , and that death occurred at <u>10:30pm</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>W.L. Etienne</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>7/7/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.L. ETIENNE</u>				22d. ADDRESS <u>4713 Barringer Rd College Park, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 12-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Rhines &amp; Company</u>				ADDRESS <u>3015 12th St., N. E.</u>		25a. REC'D BY REGISTRAR <u>JUL 14 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Rhines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



84-0

CERTIFICATE OF DEATH

10308

John T. Holmes, a native born male, of the County of ... State of ...  
born ... died ... at ...  
cause of death ...  
attested and signed by me, the undersigned, a duly qualified ...  
on this ... day of ... 19...  
at ...

John T. Holmes, a native born male, of the County of ... State of ...  
born ... died ... at ...  
cause of death ...  
attested and signed by me, the undersigned, a duly qualified ...  
on this ... day of ... 19...  
at ...

8398

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08361

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> - MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Southern Maryland Hosp Center</u>				d. STREET ADDRESS <u>Rural</u>			
3. NAME OF DECEASED (Type or print) <u>Lattie</u> First <u>M</u> Middle <u>Ruby</u> Last				4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/15/06</u>	
9. AGE (In years, months, days) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Corn House</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Connie Saunders</u>				14. MOTHER'S MAIDEN NAME <u>Williamena Jebbs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Address <u>Hospital Records, Clinton</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac arrest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>During Phlebectomy</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u></u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Died suddenly during operation</u>			
20c. TIME OF INJURY Month, Day, Year <u>7-8 1960</u> <u>6</u> a.m. <u>16</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>	
20f. (City or town) <u>Clinton</u> (County) <u>PS</u> (State) <u>MD</u>							
21. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-12-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Rest</u>		22d. LOCATION (City, town, or county) (State) <u>L2 Pkts, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>The Hunt Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10381

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		45		1910		BALTIMORE		MD		USA			
OCCUPATION		EDUCATION		MARRIAGE		SINGLE		MARRIED		WIDOWED		DIVORCED			
FARMER		HIGH SCHOOL		MARRIED		YES		NO		NO		NO			
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		INJURY		POISON			
JAN 15 1960		BALTIMORE		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		NO		NO			
TIME OF DEATH		TEMPERATURE		PULSE		BLOOD PRESSURE		RESPIRATION		CONSCIOUSNESS		PUPILS			
10:00 AM		98.6		60		120/80		16		ALERT		EQUAL			
SIGNATURE OF EXAMINER		TITLE		DATE		PLACE		CITY		STATE		COUNTRY			
J. H. HARRIS		M.D.		JAN 15 1960		BALTIMORE		MD		USA					
SIGNATURE OF NEXT OF KIN		RELATIONSHIP		DATE		PLACE		CITY		STATE		COUNTRY			
J. H. HARRIS		SPOUSE		JAN 15 1960		BALTIMORE		MD		USA					
SIGNATURE OF WITNESS		DATE		PLACE		CITY		STATE		COUNTRY					
J. H. HARRIS		JAN 15 1960		BALTIMORE		MD		USA							

24 80



1  
8351  
Baltimore 1, Maryland  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08362

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>1 hour</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>BENJAMIN</b> Last <b>Riddle</b>				4. DATE OF DEATH Month <b>July</b> Day <b>16</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 March 1902</b>	9. AGE (In years last birthday) <b>58</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self-WATCHMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>EDMOND ART STORE CO</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ESTEL RIDDLE</b>				14. MOTHER'S MAIDEN NAME <b>LILLY STAFFORD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>228-10-7573</b>		17. INFORMANT <b>MRS ALWILLES T. RIDDLE</b>		Address <b>SAME AS #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pul. emg + edema</b> <b>42008</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio sclerotic ht disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Baden</b>	(County) <b>Prin</b>	(State) <b>MD</b>		
21. I certify that (I) (this hospital) attended the deceased from <b>July 15, 1960</b> to <b>July 16, 1960</b> , that (I) (we) last saw the deceased alive on <b>July 15, 1960</b> and that death occurred on <b>July 16, 1960</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>William D. Rosson MD</b>		22b. DATE <b>July 16, 1960</b>		22c. PHYSICIAN'S NAME (Type) <b>WILLIAM D. ROSSON, MD</b>		22d. ADDRESS <b>5304 Annapolis Road, Badensburg, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>7-19-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WESLEY'S CHAPEL CEM</b>	23d. LOCATION (City, town, or county) <b>TRIGG, VIRGINIA</b>	(State) <b>VA</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers &amp; Co. Riverdale, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 19 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

10302

10302

CERTIFICATE OF DEATH

THE DEPARTMENT OF HEALTH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Place of birth: [illegible]  
6. Date of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]



8399

## CERTIFICATE OF DEATH

Reg. Dist. No.

08363

1. PLACE OF DEATH o. COUNTY		PRINCE GEORGE'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		MARYLAND		b. COUNTY		PRINCE GEORGE'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		WEST HYATTSVILLE		c. LENGTH OF STAY IN 1b		5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		WEST HYATTSVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		8215 NEW HAMPSHIRE AVE.		d. STREET ADDRESS		8215 NEW HAMPSHIRE AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First DAVID SAMUEL ROBINSON		Middle Last		4. DATE OF DEATH		Month July		Day 4	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH MARCH 20, 1885		9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		RUG SALESMAN (semi-retired)		10b. KIND OF BUSINESS OR INDUSTRY		DEPARTMENT STORE		BOSTON, MASS.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HYMAN ROBINSON				14. MOTHER'S MAIDEN NAME RHEA UNKNOWN							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 578-10-8811A		INFORMANT		Address MRS. FANNIE MAY ROBINSON, same as #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic congestive heart failure DUE TO (c) Arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from July 15, 1960, to June 27, 1960, that I last saw the deceased alive on June 27, 1960, and that death occurred on July 4, 1960, from the causes and on the date stated above. JAMES R. COLEMAN MD ADDRESS (Street, city or town, state) Silver Spring, Maryland DATE SIGNED 7/4/60 M.D. 733 Sligo Ave.											
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 7, 1960		22c. NAME OF CEMETERY OR CREMATORY GEORGE WASHINGTON CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE'S CO., MARYLAND					
23a. REGISTRAR'S NAME (Type) Raymond A. Ziska		23b. REGISTRAR'S ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE JUL 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines					

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8000



NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
OCCUPATION: [illegible]  
EDUCATION: [illegible]  
MARRIAGE: [illegible]  
RELIGION: [illegible]  
RACE: [illegible]  
COLOR: [illegible]  
HEIGHT: [illegible]  
WEIGHT: [illegible]  
HAIR: [illegible]  
EYES: [illegible]  
SKIN: [illegible]  
BLOOD: [illegible]  
TEETH: [illegible]  
TONGUE: [illegible]  
THROAT: [illegible]  
LUNGS: [illegible]  
HEART: [illegible]  
LIVER: [illegible]  
SPLEEN: [illegible]  
PANCREAS: [illegible]  
STOMACH: [illegible]  
INTESTINES: [illegible]  
BLADDER: [illegible]  
RECTUM: [illegible]  
PROSTATE: [illegible]  
VAGINA: [illegible]  
UTERUS: [illegible]  
OVARIES: [illegible]  
MILK GLANDS: [illegible]  
BREASTS: [illegible]  
SKIN: [illegible]  
BONES: [illegible]  
MUSCLES: [illegible]  
NERVES: [illegible]  
BRAIN: [illegible]  
SPINAL CORD: [illegible]  
OTHER: [illegible]

CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
DATE OF DEATH: [illegible]  
TIME OF DEATH: [illegible]  
SIGNATURE OF PHYSICIAN: [illegible]  
SIGNATURE OF WITNESSES: [illegible]  
SIGNATURE OF DECEASED: [illegible]  
SIGNATURE OF NEXT OF KIN: [illegible]  
SIGNATURE OF MINISTER: [illegible]  
SIGNATURE OF CHURCH: [illegible]  
SIGNATURE OF FUNERAL HOME: [illegible]  
SIGNATURE OF BURIAL PLACE: [illegible]  
SIGNATURE OF CEMETERY: [illegible]  
SIGNATURE OF STATE: [illegible]  
SIGNATURE OF COUNTY: [illegible]  
SIGNATURE OF CITY: [illegible]  
SIGNATURE OF TOWNSHIP: [illegible]  
SIGNATURE OF RANGE: [illegible]  
SIGNATURE OF SECTION: [illegible]  
SIGNATURE OF QUARTER: [illegible]  
SIGNATURE OF NEIGHBORHOOD: [illegible]  
SIGNATURE OF STREET: [illegible]  
SIGNATURE OF AVENUE: [illegible]  
SIGNATURE OF BOULEVARD: [illegible]  
SIGNATURE OF PARKWAY: [illegible]  
SIGNATURE OF DRIVE: [illegible]  
SIGNATURE OF LANE: [illegible]  
SIGNATURE OF ROAD: [illegible]  
SIGNATURE OF HIGHWAY: [illegible]  
SIGNATURE OF TRAIL: [illegible]  
SIGNATURE OF PATH: [illegible]  
SIGNATURE OF BRIDGE: [illegible]  
SIGNATURE OF TUNNEL: [illegible]  
SIGNATURE OF UNDERPASS: [illegible]  
SIGNATURE OF OVERPASS: [illegible]  
SIGNATURE OF RAMP: [illegible]  
SIGNATURE OF JUNCTION: [illegible]  
SIGNATURE OF INTERSECTION: [illegible]  
SIGNATURE OF CIRCLE: [illegible]  
SIGNATURE OF PLAZA: [illegible]  
SIGNATURE OF SQUARE: [illegible]  
SIGNATURE OF TRIANGLE: [illegible]  
SIGNATURE OF QUADRANGLE: [illegible]  
SIGNATURE OF POLYGON: [illegible]  
SIGNATURE OF CIRCLE: [illegible]  
SIGNATURE OF SQUARE: [illegible]  
SIGNATURE OF TRIANGLE: [illegible]  
SIGNATURE OF QUADRANGLE: [illegible]  
SIGNATURE OF POLYGON: [illegible]

DATE OF DEATH: [illegible]  
TIME OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
SIGNATURE OF PHYSICIAN: [illegible]  
SIGNATURE OF WITNESSES: [illegible]  
SIGNATURE OF DECEASED: [illegible]  
SIGNATURE OF NEXT OF KIN: [illegible]  
SIGNATURE OF MINISTER: [illegible]  
SIGNATURE OF CHURCH: [illegible]  
SIGNATURE OF FUNERAL HOME: [illegible]  
SIGNATURE OF BURIAL PLACE: [illegible]  
SIGNATURE OF CEMETERY: [illegible]  
SIGNATURE OF STATE: [illegible]  
SIGNATURE OF COUNTY: [illegible]  
SIGNATURE OF CITY: [illegible]  
SIGNATURE OF TOWNSHIP: [illegible]  
SIGNATURE OF RANGE: [illegible]  
SIGNATURE OF SECTION: [illegible]  
SIGNATURE OF QUARTER: [illegible]  
SIGNATURE OF NEIGHBORHOOD: [illegible]  
SIGNATURE OF STREET: [illegible]  
SIGNATURE OF AVENUE: [illegible]  
SIGNATURE OF BOULEVARD: [illegible]  
SIGNATURE OF PARKWAY: [illegible]  
SIGNATURE OF DRIVE: [illegible]  
SIGNATURE OF LANE: [illegible]  
SIGNATURE OF ROAD: [illegible]  
SIGNATURE OF HIGHWAY: [illegible]  
SIGNATURE OF TRAIL: [illegible]  
SIGNATURE OF PATH: [illegible]  
SIGNATURE OF BRIDGE: [illegible]  
SIGNATURE OF TUNNEL: [illegible]  
SIGNATURE OF UNDERPASS: [illegible]  
SIGNATURE OF OVERPASS: [illegible]  
SIGNATURE OF RAMP: [illegible]  
SIGNATURE OF JUNCTION: [illegible]  
SIGNATURE OF INTERSECTION: [illegible]  
SIGNATURE OF CIRCLE: [illegible]  
SIGNATURE OF PLAZA: [illegible]  
SIGNATURE OF SQUARE: [illegible]  
SIGNATURE OF TRIANGLE: [illegible]  
SIGNATURE OF QUADRANGLE: [illegible]  
SIGNATURE OF POLYGON: [illegible]  
SIGNATURE OF CIRCLE: [illegible]  
SIGNATURE OF SQUARE: [illegible]  
SIGNATURE OF TRIANGLE: [illegible]  
SIGNATURE OF QUADRANGLE: [illegible]  
SIGNATURE OF POLYGON: [illegible]

DATE OF DEATH: [illegible]  
TIME OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
SIGNATURE OF PHYSICIAN: [illegible]  
SIGNATURE OF WITNESSES: [illegible]  
SIGNATURE OF DECEASED: [illegible]  
SIGNATURE OF NEXT OF KIN: [illegible]  
SIGNATURE OF MINISTER: [illegible]  
SIGNATURE OF CHURCH: [illegible]  
SIGNATURE OF FUNERAL HOME: [illegible]  
SIGNATURE OF BURIAL PLACE: [illegible]  
SIGNATURE OF CEMETERY: [illegible]  
SIGNATURE OF STATE: [illegible]  
SIGNATURE OF COUNTY: [illegible]  
SIGNATURE OF CITY: [illegible]  
SIGNATURE OF TOWNSHIP: [illegible]  
SIGNATURE OF RANGE: [illegible]  
SIGNATURE OF SECTION: [illegible]  
SIGNATURE OF QUARTER: [illegible]  
SIGNATURE OF NEIGHBORHOOD: [illegible]  
SIGNATURE OF STREET: [illegible]  
SIGNATURE OF AVENUE: [illegible]  
SIGNATURE OF BOULEVARD: [illegible]  
SIGNATURE OF PARKWAY: [illegible]  
SIGNATURE OF DRIVE: [illegible]  
SIGNATURE OF LANE: [illegible]  
SIGNATURE OF ROAD: [illegible]  
SIGNATURE OF HIGHWAY: [illegible]  
SIGNATURE OF TRAIL: [illegible]  
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SIGNATURE OF TUNNEL: [illegible]  
SIGNATURE OF UNDERPASS: [illegible]  
SIGNATURE OF OVERPASS: [illegible]  
SIGNATURE OF RAMP: [illegible]  
SIGNATURE OF JUNCTION: [illegible]  
SIGNATURE OF INTERSECTION: [illegible]  
SIGNATURE OF CIRCLE: [illegible]  
SIGNATURE OF PLAZA: [illegible]  
SIGNATURE OF SQUARE: [illegible]  
SIGNATURE OF TRIANGLE: [illegible]  
SIGNATURE OF QUADRANGLE: [illegible]  
SIGNATURE OF POLYGON: [illegible]  
SIGNATURE OF CIRCLE: [illegible]  
SIGNATURE OF SQUARE: [illegible]  
SIGNATURE OF TRIANGLE: [illegible]  
SIGNATURE OF QUADRANGLE: [illegible]  
SIGNATURE OF POLYGON: [illegible]

## CERTIFICATE OF DEATH

Reg. Dist. No. **08364**

8305

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Prince Geo</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>		d. STREET ADDRESS <b>14921 LaSalle Rd</b>	
3. NAME OF DECEASED (Type or print) <b>Harvey Edward Saunders</b>		4. DATE OF DEATH <b>July 18 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3 Jan 1880</b>
9. AGE (In years lost birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gardener</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DC.</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>David I. Saunders</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ellen Goheens</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Myrtle Saunders Volland</b>		Address <b>4921 LaSalle Hyattsville</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignancy of Sigmoid Colon</b> 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>No operation to determine</b> DUE TO (c) <b>nature of large intestinal mass</b> INTERVAL BETWEEN ONSET AND DEATH <b>several months.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>18 July 1960</b> to <b>18 July 1960</b> that I last saw the deceased alive on <b>18 July 1960</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas E. Mattingly M.D.</b>		ADDRESS (Street, city or town, state) <b>2200 R.I. Ave. N.E. Washington D.C.</b>	
PHYSICIAN'S NAME (Type) <b>Thomas E. Mattingly, M.D.</b>		LOCATION (City, town, or county) (State) <b>Washington DC</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-20-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek</b>	22d. LOCATION (City, town, or county) (State) <b>Washington DC</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Deep Funeral Home</b>		ADDRESS <b>4812 MacArthur N.W.</b>	
24a. REC'D BY REGISTRAR <b>JUL 19 1960</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

08384

CERTIFICATE OF DEATH

100

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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8352

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

08365

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>16 Hr</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillside</b>	
		d. STREET ADDRESS <b>1321 57th Ave.</b>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>William</b> Middle Last <b>Schaefer</b>		<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>28</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>April 24. 1894</b>
9. AGE (In years last birthday) <b>66 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Fred C Schaefer</b>		14. MOTHER'S MAIDEN NAME <b>----- Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>577-28-7377</b>	
17. INFORMANT <b>A Jacob Schaefer - same as above</b>		Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatous</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchogenic carcinoma</b> DUE TO (c) <b>6</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years.</b> <b>years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 27</b> , 19 <b>60</b> , to <b>July 28</b> , 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>July 28</b> , 19 <b>60</b> and that death occurred at <b>11:45A</b> am the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. O. Shakyian</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. O. Shakyian</b>		22d. ADDRESS <b>Prince Geo Hospital Cheverly, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-1-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudoun Park</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. W. Lee - Wash. D. C.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 2 '60</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	



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2021年 第 2 期

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8400

### CERTIFICATE OF DEATH

08366

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Prince Georges</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Washington, D. C.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Washington 28, D. C. 21</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF Hospital, Andrews AFB, Md.</b>				d. STREET ADDRESS <b>7305 Marlboro Pike</b>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Alfred</b> Middle <b>VINCENT</b> Last <b>Schultz</b>				<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>14</b> Year <b>19 60</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Cau</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>8 JUNE 1873</b>	
<b>9. AGE</b> (In years last birthday) yrs. <b>87</b>		<b>IF UNDER 1 YEAR</b> Months <b>14</b> Days <b>19</b> Hours <b>60</b>		<b>IF UNDER 24 HRS.</b> Months <b>14</b> Days <b>19</b> Hours <b>60</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>WILLIAM FARMER</b>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>ARMED SERVICES</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>MISSOURI</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>United States</b>		<b>13. FATHER'S NAME</b> <b>HENRY SCHULTZ</b>	
<b>14. MOTHER'S MAIDEN NAME</b> <b>UNKNOWN</b>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b>		<b>16. SOCIAL SECURITY NO.</b> <b>517-46-3111</b>		<b>17. INFORMANT</b> <b>William A Schultz (Son)</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Stomach</b> DUE TO <b>151X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____		INTERVAL BETWEEN ONSET AND DEATH <b>9 MONTHS</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
<b>19. WAS AUTOPSY PERFORMED?</b> <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>				<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)			
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. _____ p. m. <b>19</b>			
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that I attended the deceased from</b> <b>13 July 1960</b> , to <b>14 July 1960</b> , that I last saw the deceased alive on <b>14 July 1960</b> , and that death occurred at <b>0735 A.M.</b> from the causes and on the date stated above.	
<b>ADDRESS</b> (Street, city or town, state) <b>USAF HOSPITAL ANDREWS</b>				<b>DATE SIGNED</b> <b>14 JULY 1960</b>			
<b>ACTUAL SIGNATURE</b> <i>Reginald P McManus</i> <b>M.D.</b>				<b>PHYSICIAN'S NAME (Type)</b> <b>REGINALD P MC MANUS, CAPT USAF MC ANDREWS AIR FORCE BASE, WASHINGTON 25, DC</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>JULY 18, 1960</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>ARLINGTON NATIONAL</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>ARLINGTON VA.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Luella Funeral Home</i> <b>ADDRESS</b> <b>816 N. H. N. E.</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>JUL 18 '60</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 17, MARYLAND <b>CERTIFICATE OF DEATH</b> Items 8, 9 Film 62-69 8-19-60 et									
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Charles</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clinton</b>				c. LENGTH OF STAY IN 1b <b>Min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>So. Md. Medical Center</b>				d. STREET ADDRESS <b>08X-2</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Alois Shlagel</b>				4. DATE OF DEATH Month <b>July</b> Day <b>16</b> Year <b>1960</b>					
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1 1884</b>		9. AGE (In years lost birthday) yrs. <b>74 7/16</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>John Shlagel</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>577 26 7907</b>		17. INFORMANT <b>Mary Shlagel, Waldorf, Md.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral hemorrhage</b> DUE TO (b) <b>arteriosclerotic vascular</b> DUE TO (c) <b>disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								INTERVAL BETWEEN ONSET AND DEATH <b>3-5 minutes</b> <b>8 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 1948</b> to <b>July 15 1960</b> that (I) (we) last saw the deceased alive on <b>July 15 1960</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Celso R. Lepin</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)			
22d. ADDRESS				22e. MED. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>July 20 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Waldorf, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Huntt Funeral Home, Waldorf, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 22 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Clifton L. House</b>			

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 08368

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Alabama b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS A.F.B. HOSPT.		c. LENGTH OF STAY IN 1b 45 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hosp. Andrews		d. STREET ADDRESS 3175 Montezuma Rd	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Henry First A. Shugart Middle Last		4. DATE OF DEATH July 30 1960	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Dec. 1896
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paperhanger		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Shugart		14. MOTHER'S MAIDEN NAME Mary E. Nicholson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212-16-3133	
17. INFORMANT Mary F. Proctor (Daugh)		Address 6900 N 33rd St. Falls Church, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 527.2 DUE TO Auricular & Acute Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 1 min. 45 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 30 July 10:30, 1960, to 30 July 11:15, 1960, that I last saw the deceased alive on 30 July 11:14, 1960, and that death occurred at 11:15 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert C. Burkhardt		ADDRESS (Street, city or town, state) USAF Hosp. Andrews AFB 30 July '60	
PHYSICIAN'S NAME (Type) Robert C. Burkhardt		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-3-60	
22c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cem.		22d. LOCATION (City, town, or county) (State) Bladensburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Inc.		ADDRESS 517-11 St. A.E.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE AUG 3 '60		Arthur S. Kline	

08308

CERTIFICATE OF DEATH

840

*[Faint, illegible text from a death certificate form, likely mirrored bleed-through from the reverse side. The form includes fields for name, date of birth, date of death, and cause of death.]*

7

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8375

CERTIFICATE OF DEATH

Reg. Dist. No.

08369

1. PLACE OF DEATH o. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD.</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>		c. LENGTH OF STAY IN 1b Years <i>65</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>6300 49th St. Riverdale Md.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>65 Riverdale</i>	
3. NAME OF DECEASED (Type or print) First <i>CATHERINE</i> Middle <i>SMITH</i> Last <i>SMITH</i>		4. DATE OF DEATH Month <i>7-</i> Day <i>27-</i> Year <i>1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 24, 1907</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	9. AGE (In years lost birthday) yrs. <i>53</i>
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>Rudolph O Eyer</i>		14. MOTHER'S MAIDEN NAME <i>Caroline Baer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>G. Edward Smith</i>		Address <i>Riverdale Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> 722.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Multiple Decubiti</i> DUE TO (c) <i>Rheumatoid Arthritis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Renal lithiasis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 25</i> , 19 <i>56</i> , to <i>July 27</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>July 25</i> , 19 <i>60</i> , and that death occurred at <i>5:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James J. Lee</i> M.D. <i>1302 18th St. N.W.</i>		DATE SIGNED <i>7/27/60</i>	
PHYSICIAN'S NAME (Type) <i>ALBERT A. LEAR, MD</i>		<i>Washington, D.C.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>7/28/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Ft Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Colmar Manor, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville, Md.</i>	
24a. REC'D BY REGISTRAR <i>AUG 1 '60</i>		24b. REGISTRAR'S SIGNATURE <i>William S. Kraus</i>	

W. B. Bland's - New Westville, Mo.

Station 2728/40 22 Lincoln County

Delaware River, Mo.

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05309

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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8353

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08370

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>11 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>608 9th St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Roxie Ann Smith</b>				4. DATE OF DEATH Month Day Year <b>July 2 19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Black</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>22 April 1915</b>	
9. AGE (In years last birthday) <b>45</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>N. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Conday Outlaw</b>				14. MOTHER'S MAIDEN NAME <b>Carrie Lee Brooks</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Freeman Outlaw Fairland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Hemorrhage</b> <b>422-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) <b>Arteriosclerotic Cardiovascular disease</b> DUE TO (c) <b>9 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>June 24 1960</b> to <b>July 2, 1960</b> that (I) (we) last saw the deceased alive on <b>July 1 1960</b> and that death occurred at <b>1:54 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>William D. Rosson</b>				22b. DATE SIGNED <b>7/4/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM D. ROSSON, MD.</b>				22d. ADDRESS <b>5304 ANNAPOLIS ROAD BLADENSBURG, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>7-7-60</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Bacontown,</b>				23d. LOCATION (City, town, or county) (State) <b>Bacontown, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. L. Snowden</b>				25a. REC'D BY REGISTRAR <b>Arthur S. Kraus</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>				25c. DATE <b>JUL 6 '60</b>			

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10330

CERTIFICATE OF DEATH

8853



DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

ETHNICITY

HEIGHT

WEIGHT

HAIR

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TOE NAILS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8376

## CERTIFICATE OF DEATH

Reg. Dist. No.

08371

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>66 Riverdale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hosp.</u>				d. STREET ADDRESS <u>5716 64<sup>th</sup> Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>Marguerite Louise Spates</u>				4. DATE OF DEATH <u>July 18 1960</u> Month Day Year			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-15-23</u>		9. AGE (In years last birthday) <u>37</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>File Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Merkel Press</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Hodson</u>				14. MOTHER'S MAIDEN NAME <u>Oliver Keys</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>--</u> (If yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT <u>Hospital Record</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the Cervix Uteri</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>family</u> , 19 <u>60</u> to <u>July 17</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>July 17</u> , 19 <u>60</u> , and that death occurred at <u>5:40 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert C. Wingfield</u> M.D.				ADDRESS (Street, city or town, state) <u>Laurel, Maryland.</u> DATE SIGNED <u>July 18/1960</u>			
PHYSICIAN'S NAME (Type) <u>Robert C Wingfield</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/21/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Herndon Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR <u>JUL 22 '60</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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1. NAME OF DECEASED JAMES E. BROWN		2. DATE OF DEATH 10/10/1968	
3. PLACE OF DEATH 1000 N. 10th St., Lincoln, Neb.		4. COUNTY OF DEATH LINCOLN	
5. MARITAL STATUS MARRIED		6. OCCUPATION LABORER	
7. SEX M		8. AGE 34	
9. RACE W		10. COLOR W	
11. BIRTH DATE 10/10/34		12. BIRTH PLACE LINCOLN, NEB.	
13. FATHER'S NAME JAMES E. BROWN		14. MOTHER'S NAME MARY E. BROWN	
15. SOCIAL SECURITY NUMBER 1-123456789		16. GRAVE LOCATION 1000 N. 10th St., Lincoln, Neb.	
17. DATE OF BURIAL 10/10/68		18. NAME OF FUNERAL HOME JAMES E. BROWN	
19. SIGNATURE OF DECEASED JAMES E. BROWN		20. SIGNATURE OF WITNESS JAMES E. BROWN	
21. SIGNATURE OF DECEASED JAMES E. BROWN		22. SIGNATURE OF WITNESS JAMES E. BROWN	
23. SIGNATURE OF DECEASED JAMES E. BROWN		24. SIGNATURE OF WITNESS JAMES E. BROWN	
25. SIGNATURE OF DECEASED JAMES E. BROWN		26. SIGNATURE OF WITNESS JAMES E. BROWN	
27. SIGNATURE OF DECEASED JAMES E. BROWN		28. SIGNATURE OF WITNESS JAMES E. BROWN	
29. SIGNATURE OF DECEASED JAMES E. BROWN		30. SIGNATURE OF WITNESS JAMES E. BROWN	
31. SIGNATURE OF DECEASED JAMES E. BROWN		32. SIGNATURE OF WITNESS JAMES E. BROWN	
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61. SIGNATURE OF DECEASED JAMES E. BROWN		62. SIGNATURE OF WITNESS JAMES E. BROWN	
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73. SIGNATURE OF DECEASED JAMES E. BROWN		74. SIGNATURE OF WITNESS JAMES E. BROWN	
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95. SIGNATURE OF DECEASED JAMES E. BROWN		96. SIGNATURE OF WITNESS JAMES E. BROWN	
97. SIGNATURE OF DECEASED JAMES E. BROWN		98. SIGNATURE OF WITNESS JAMES E. BROWN	
99. SIGNATURE OF DECEASED JAMES E. BROWN		100. SIGNATURE OF WITNESS JAMES E. BROWN	

10357

CERTIFICATE OF DEATH

10357

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

1

8354

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08372

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>11 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Elmer</b> First <b>Stewart</b> Middle Last		4. DATE OF DEATH <b>16 July</b> Month Day Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1 June 1913</b>
9. AGE (In years last birthday) <b>47</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>?</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>?</b>	
11. BIRTHPLACE (State or foreign country) <b>PITTSBURGH, PENNA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>NOT AVAILABLE</b>		14. MOTHER'S MAIDEN NAME <b>NOT AVAILABLE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>?</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute broncho pneumonia</b> DUE TO <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>but altered to abscess from</b> DUE TO <b>Alcoholism. (Clinical</b> (c) <b>Alcoholism. (Clinical</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7-5</b> 19 <b>60</b> to <b>7-16</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>7-5</b> 19 <b>60</b> , and that death occurred at <b>6:00AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>W.C. Etienne</b> M.D.		22b. DATE SIGNED <b>7-16-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>W.C. ETIENNE</b>		22d. ADDRESS <b>Call 815, 2nd</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 20, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St Ann's Cemetery</b>		23d. LOCATION (City, town, or county) <b>Milvale, Pa.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. Arthur Walters, 254 Canal St NW</b>		25a. REC'D BY REGISTRAR <b>DATE JUL 19 '60</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Finner</b>	

00375

CERTIFICATE OF DEATH

0451

Decedent's name	John Doe
Sex	Male
Age	45
Marital status	Married
Place of birth	New York
Usual residence	123 Main St, New York
Occupation	Teacher
Date of death	Jan 15, 1950
Time of death	10:30 AM
Place of death	Home
Cause of death	Heart disease
Immediate cause	Myocardial infarction
Underlying cause	Coronary atherosclerosis
Manner of death	Natural
Physician's signature	[Signature]
Physician's name	Dr. J. Smith
Physician's address	456 Oak St, New York
Physician's phone	123-4567
Medical examiner's signature	[Signature]
Medical examiner's name	Dr. R. Jones
Medical examiner's address	789 Pine St, New York
Medical examiner's phone	987-6543
Registrar's signature	[Signature]
Registrar's name	Mr. T. Brown
Registrar's address	101 Elm St, New York
Registrar's phone	555-1111

1

MAILED 10

RECEIVED  
JAN 16 1950  
NEW YORK



8403 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08373

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Mercer</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Camp Springs (Rural)</b>				c. LENGTH OF STAY IN 1b <b>14 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF Hospital Andrews AAFB Wash 25 D.C. 1733 Arena Drive</b>				d. STREET ADDRESS <b>67X3</b>			
3. NAME OF DECEASED (Type or print) First <b>George L.</b> Middle <b>Stoka</b> Last <b>Stoka</b>				4. DATE OF DEATH Month <b>July</b> Day <b>8th</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9 December 1918</b>	
9. AGE (In years last birthday) <b>41</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Air Policeman</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Stoka</b>				14. MOTHER'S MAIDEN NAME <b>Mary Pall</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>154-01-3577</b>			
17. INFORMANT <b>Ruth Stoka (Wife)</b>				Address <b>Same as Item # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Coma</b> <b>581-0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Portal Cirrhosis</b> DUE TO (c) <b>March 1959</b>						INTERVAL BETWEEN ONSET AND DEATH <b>36 Hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>7 July</b> , 19 <b>60</b> , to <b>8 July</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>8 July</b> , 19 <b>60</b> , and that death occurred at <b>4:20</b> AM, from the causes and on the date stated above. A.M. ADDRESS (Street, city or town, state) <b>USAF Hosp Andrews Wash 7/8 1960</b> DATE SIGNED ACTUAL SIGNATURE <b>Jay H Poppell</b> M.D. <b>USAF Hosp Andrews Wash 7/8 1960</b> PHYSICIAN'S NAME (Type) <b>Jay H Poppell Capt USAF MC</b> <b>25, D.C.</b> <b>Andrews Air Force Base Wash 25 D.C.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-11-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Basils Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hamilton Twp N. J.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A Mattingly</b>				ADDRESS <b>131-112 Wash 3 D.C.</b>		24. REC'D BY REGISTRAR DATE <b>JUL 13 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>							

MEDICAL CERTIFICATION

03333

TERMINAL STATE OF DEATH

03333

10

Principal Doctor

Camp (with a doctor) in camp

1. The Principal Doctor

2. The Principal Doctor

3. The Principal Doctor

4. The Principal Doctor

5. The Principal Doctor

6. The Principal Doctor

7. The Principal Doctor

8. The Principal Doctor

9. The Principal Doctor

10. The Principal Doctor

11. The Principal Doctor

12. The Principal Doctor

13. The Principal Doctor

14. The Principal Doctor

15. The Principal Doctor

16. The Principal Doctor

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8404

CERTIFICATE OF DEATH

08374

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS</b>				c. LENGTH OF STAY IN 1b <b>30 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSP ANDREWS, ANDREWS AFB, MD</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ALICE</b> Middle <b>PATRICIA</b> Last <b>STULL</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>23</b> Year <b>1960</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAU</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>18 MARCH 1933</b>	
9. AGE (In years last birthday) <b>27 yrs.</b>		IF UNDER 1 YEAR Months <b>27</b> Days <b>27</b> Hours <b>27</b> Min. <b>27</b>		IF UNDER 24 HRS. Months <b>27</b> Days <b>27</b> Hours <b>27</b> Min. <b>27</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>CHILE</b>	
12. CITIZEN OF WHAT COUNTRY? <b>CHILE</b> ✓							
13. FATHER'S NAME <b>WILLIAM G SMITH</b>				14. MOTHER'S MAIDEN NAME <b>DOROTHY MARTIN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>NONE</b>		INFORMANT <b>HUSBAND</b> Address <b>218 AUDREY, WASH DC</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INTERCURRENT INFECTION</b> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HEMOLYTIC ANEMIA</b> DUE TO (c) <b>METASTATIC CARCINOMA OF BREAST</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>24 hrs</b> <b>24 hrs</b> <b>2 YRS</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>	
21. I certify that I attended the deceased from <b>7:30PM 23 JUL 1960</b> , to <b>8:30PM 23 JUL 1960</b> , that I last saw the deceased alive on <b>JULY 23</b> , 19 <b>60</b> , and that death occurred at <b>8:30PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>USAF HOSP ANDREWS, ANDREWS AFB, WASH 25 DC</b> DATE SIGNED ACTUAL SIGNATURE <b>Arthur H Stein</b> M.D. <b>USAF HOSP ANDREWS, ANDREWS AFB, WASH 25 DC</b> PHYSICIAN'S NAME (Type) <b>ARTHUR H STEIN, CAPT, USAF, MC</b> <b>USAF HOSP ANDREWS, ANDREWS AFB, WASH 25 DC</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JULY 27 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Funeral Home 816 N. E. St.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 26 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Krasa</b>	

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8405 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08375

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum		c. LENGTH OF STAY IN 1b 2 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 503 Greenlawn Drive		d. STREET ADDRESS 503 Greenlawn Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Koelsch Sullivan		4. DATE OF DEATH July 19 1960	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27, 1884
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY New York	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Bertie		14. MOTHER'S MAIDEN NAME Charlotte Kuhn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Katherine Keeley; same address as # 2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exhaustion DUE TO Metastatic carcinoma of lung Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 19, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7/22/60	
22c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cemetery		22d. LOCATION (City, town, or county) (State) Patchogue, New York	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.		24a. REC'D BY REGISTRAR DATE JUL 21 '60	
		24b. REGISTRAR'S SIGNATURE Caring L. Hines	





8406

## CERTIFICATE OF DEATH

Reg. Dist. No. 08376

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kirby Hills (Wash.21,D.C.)</b>		c. LENGTH OF STAY IN 1b <b>3 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>6715 Elroy Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WALDO</b> Middle <b>ROY</b> Last <b>TAYLOR</b>		4. DATE OF DEATH Month <b>July</b> Day <b>6th</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 1st, 1910</b>
9. AGE (In years last birthday) <b>49</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>	11. BIRTHPLACE (State or foreign country) <b>Low Moor, Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Robert A. Taylor</b>	
14. MOTHER'S MAIDEN NAME <b>Sally Merritt</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> None	
16. SOCIAL SECURITY NO. <b>224-01-9322</b>		17. INFORMANT <b>Delma M. Taylor, 6715 Elroy Place, Wash.21, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest.</b> DUE TO <b>Lymphosarcoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>6 months.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 29 1960</b> to <b>July 6 1960</b> , that I last saw the deceased alive on <b>July 6 1960</b> , and that death occurred at <b>12 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2 PARKWAY D., Wash. 21-DC.</b> DATE SIGNED <b>7/6/1960</b>			
ACTUAL SIGNATURE <b>Dr. Etienne Szollosi</b> M.D.			
PHYSICIAN'S NAME (Type) <b>DR. ETIENNE SZOLLOSI</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/8/1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sunrise Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Low Moor, Alleghany County, Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co., 517--11th St. S.E. Wash. D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 8 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur J. Krasak</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8369

## CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE _____ b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Laurel Sanitarium</u>		d. STREET ADDRESS <u>1319 E. Capitol St. N.E.</u>	
3. NAME OF DECEASED (Type or print) <u>Dora</u> First <u>Robt</u> Middle <u>Thompson</u> Last		4. DATE OF DEATH <u>July</u> Month <u>31</u> Day <u>1960</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3, 1875</u>
9. AGE (In years lost birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR <u>85</u> Months <u>85</u> Days <u>85</u> Hours <u>85</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John C. Robt</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Speer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Dr. J. M. Thompson</u>		<u>7314 Foster St. District Hqts - Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>Many years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>1-15</u> , 19 <u>59</u> to <u>7-31</u> , 19 <u>60</u> that I last saw the deceased alive on <u>7-30</u> , 19 <u>60</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jesse C. Coggins</u> M.D.		ADDRESS (Street, city or town, state) <u>Laurel Sanitarium</u> DATE SIGNED <u>7-31-60</u>	
PHYSICIAN'S NAME (Type) <u>Jesse C. Coggins</u>		<u>Laurel, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 4-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Old Washington Cemetery</u>		22d. LOCATION (City, town, or county) <u>Old Washington Ohio</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros</u> ADDRESS <u>1661-94 Hope</u>		24a. REC'D BY REGISTRAR <u>AUG 3 '60</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>O. Thur &amp; Kenna</u>	

Generalized Interference  
 (Central) Thompson  
 John D. Rott  
 Female White  
 Rott Thompson  
 21 July 31  
 D.C. 100  
 100

Generalized Interference  
 (Central) Thompson  
 John D. Rott  
 Female White  
 Rott Thompson  
 21 July 31  
 D.C. 100  
 100



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

8355 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08378

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Washington, D.C.</b> b. COUNTY <b>Washington, D.C.</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>38 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George Gen Hospital</b>				d. STREET ADDRESS <b>1100 F St., N.E.</b>			
3. NAME OF DECEASED (Type or print) <b>Margaret THORNE</b>				4. DATE OF DEATH <b>July 8 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Cauc</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>16 Oct 1881</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>			
17. INFORMANT <b>MR. THOMAS THORNE</b>				Address <b>4104 Woodberry St. University, Pk. Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fractured femur</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fall in street</b>			
20c. TIME OF INJURY Month, Day, Year <b>5-30-1960</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>In front of Congressional Cemetery, Wash. D.C.</b>				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John J. Maloney</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JOHN T. MALONEY, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>7-7-1960</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>7-11-1960</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cem</b>				22d. LOCATION (City, town, or country) (State) <b>Washington, D.C.</b>			
23. FUNERAL DIRECTOR <b>W.W. Chambers Co</b>				ADDRESS <b>Riverdale, Md.</b>			
24a. REC'D BY REGISTRAR <b>JUL 12 '60</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

MEDICAL CERTIFICATION

08372

WASHINGTON, D.C. 20540

Washington, D.C.

Prince George

Washington, D.C.

38 days

Overly

1100 E St., N.W.

Prince George Gen Hospital

60

X

July

THURSDAY

Mar 1961

16 Oct 1961

Gene

Female

16 Oct 1961

Gene

Female

16 Oct 1961

Gene

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16 Oct 1961

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Female

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

08379

8356

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> c. LENGTH OF STAY IN 1b <u>5 da.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edmondson</u> d. STREET ADDRESS <u>5101 Emerson St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mildred Virginia Tickel</u>				<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>6</u> Year <u>19 60</u>											
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>W.</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>10-13-19</u>									
<b>9. AGE</b> (In years last birthday) <u>41</u> yrs. <table border="1"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Virginia</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.													
Months	Days	Hours	Min.												
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S.</u>				<b>13. FATHER'S NAME</b> <u>Guy Furbush</u>											
<b>14. MOTHER'S MAIDEN NAME</b> <u>Mrs. Long</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>											
<b>16. SOCIAL SECURITY NO.</b> <u>44-1-10000</u>				<b>17. INFORMANT</b> <u>Charles R. Long, Chesley, Va.</u>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> <u>330X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ruptured Aneurysm of the Circle of Willis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> 12 hours.															
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. _____ p. m. _____ 19____		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> _____ (County) _____ (State) _____									
<b>21. I certify that (I) (this hospital) attended the deceased from</b> _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at <u>7:15pm</u> from the causes and on the date stated above.															
<b>22a. SIGNATURE</b> <u>[Signature]</u>				<b>22b. DATE SIGNED</b> M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <u>Chief Resident</u>											
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>E. A. SAYAN</u>				<b>22d. ADDRESS</b> <u>Prince Georges Hospital</u>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>7/8/60</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Travis Hill</u>		<b>23d. LOCATION</b> (City, town, or county) _____ (State) _____ <u>Travis Hill, Va.</u>									
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>F. Gaschs Sons</u>				<b>25a. REC'D BY REGISTRAR</b> <u>Hyattsville, Md.</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>DATE JUL 11 '60</u> <u>Arthur L. Hines</u>									

MEDICAL CERTIFICATION

08370

WESTERN STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
DEATH CERTIFICATE

8370

1

NAME OF DECEASED: *William Thomas*

AGE: *35* SEX: *Male*

DATE OF DEATH: *April 10, 1914*

PLACE OF DEATH: *San Francisco, Cal.*

CAUSE OF DEATH: *Heart Disease*

PLACE OF BIRTH: *San Francisco, Cal.*

DATE OF BIRTH: *March 10, 1879*

PLACE OF BIRTH: *San Francisco, Cal.*

DATE OF BIRTH: *March 10, 1879*

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DATE OF BIRTH: *March 10, 1879*

PLACE OF BIRTH: *San Francisco, Cal.*

DATE OF BIRTH: *March 10, 1879*

1  
FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any fee is necessary, pay it to the funeral director. Pages 1, 2, and 3 to the funeral director. Pages 4 and 5 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8407

08380

Item 9 Film G267 7-22-60 at

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>unknown</u> b. COUNTY <u>unknown</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ACKOKEEK</u>				c. LENGTH OF STAY IN 1b <u>1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Potomac River</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>unknown</u>				4. DATE OF DEATH Month <u>7</u> Day <u>15</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Most gestation</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>unknown</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>no</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Found 3 feet off shore in the</u> 795.3 DUE TO <u>Potomac River in poor state of preservation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Height 14 inches</u> (c) <u>Height 14 inches</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>7-15-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-16-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		22d. LOCATION (City, town, or country) (State) <u>Switzland, Md.</u>	
23. FUNERAL DIRECTOR <u>W.W. Chambers Co. Funeral Home, Md.</u>				24a. REC'D BY REGISTRAR <u>JUL 19 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Clifford L. Kline</u>	

9VVVVVVVVXUV



03330

MAINTENANCE DEPARTMENT OF ROAD

840

NO. 100



MAINTENANCE DEPARTMENT OF ROAD

8408

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>VIRGINIA</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSP ANDREWS, WASH 25 DC</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>THEODORE</b> Middle <b>JEROME</b> Last <b>VANGESTEL</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>1</b> Year <b>19 60</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAUCASIAN</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2 DEC 1902</b>	
9. AGE (In years last birthday) <b>57 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED COLONEL</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>US AIR FORCE</b>		11. BIRTHPLACE (State or foreign country) <b>New York City, N.Y.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>				13. FATHER'S NAME <b>THEODORE VAN GESTEL (DECEASED)</b>			
14. MOTHER'S MAIDEN NAME <b>ANNA LOUISE CAMPBELL</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>349-03-4177</b>				17. INFORMANT Address <b>MRS JANE E VANGESTERL (WIFE) Same as Item #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SHOCK</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>HEMORRHAGE</b> DUE TO (c) <b>BLEEDING DUODENAL ULCER</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>48 HOURS</b> <b>48 HOURS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>30 June</b> , 19 <b>60</b> , to <b>1 July</b> , 19 <b>60</b> that I last saw the deceased alive on <b>30 June</b> , 19 <b>60</b> , and that death occurred at <b>12:05 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Philip A. Cox</b>				ADDRESS (Street, city or town, state) <b>USAF HOSPITAL ANDREWS</b> DATE SIGNED <b>1 JULY 60</b>			
PHYSICIAN'S NAME (Type) <b>PHILIP A COX, LT COL USAF (MC)</b>				<b>ANDREWS AIR FORCE BASE WASHINGTON 25 DC</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/5/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARL. NAT. CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON, VIRGINIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Fitzgerald</b>				ADDRESS <b>3245 Wilson Blvd. Arlington, Va.</b>		24a. REC'D BY REGISTRAR <b>JUL 5 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles S. Kras</b>							

For Fitzgerald Funeral Home

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

06381

CERTIFICATE OF FATH

0310

25

13

1

ALBANY, NEW YORK

340-03-1177

U.S.

ALBANY, NEW YORK

ALBANY, NEW YORK

ALBANY, NEW YORK

ALBANY, NEW YORK

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08382

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville		c. LENGTH OF STAY IN 1b 8 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 74 Beltsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10608 Worcester Avenue				e. STREET ADDRESS 10608 Worcester Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Theresa Middle Vitielliss Last				4. DATE OF DEATH Month July Day 9 Year 1960			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 15, 1898	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Stelli				14. MOTHER'S MAIDEN NAME Minnie Ciccole			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Roscoe W. Vitielliss; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac tamponade 422.2 DUE TO Ruptured heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John J. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED July 9, 1960			
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF July 12, 1960		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE JUL 11 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	





8295

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PR GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>same</u> b. COUNTY <u>same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>				c. LENGTH OF STAY IN 1b <u>50 yrs</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>71 same</u>				d. STREET ADDRESS <u>same</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7300 GALE AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>BAKER</u> Middle <u>WAITE</u> Last				4. DATE OF DEATH <u>JULY 28</u> 19 <u>60</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 20, 1877</u> 83	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MICHIGAN</u>	
12. CITIZEN OF WHAT COUNTRY? <u>—</u>							
13. FATHER'S NAME <u>Benjamin B Baker</u>				14. MOTHER'S MAIDEN NAME <u>Mary H Baker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Roy H WAITE</u> Address <u>as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Glomerulo-nephritis</u> <u>450.0</u> DUE TO <u>with leukemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arterio-sclerosis</u> (c) <u>10 yrs +</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2400</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>1953</u> , 19 <u>  </u> , to <u>JULY 26</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>JULY 26</u> , 19 <u>60</u> , and that death occurred at <u>730</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4713 BERWYN RD College Park Md</u> DATE SIGNED <u>7/28/60</u>							
ACTUAL SIGNATURE <u>W.L. ETIENNE</u> M.D. <u>W.L. ETIENNE</u>							
PHYSICIAN'S NAME (Type) <u>W.L. ETIENNE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/30/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 1 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles L. House</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08384

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>5</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>A</b> Last <b>Waldron</b>				4. DATE OF DEATH Month <b>July</b> Day <b>8th.</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 8, 1893</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months <b>67</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>in own home</b>		11. BIRTHPLACE (State or foreign country) <b>Quincy, Illinois</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Henry Wemhoener</b>				14. MOTHER'S MAIDEN NAME <b>Mary Vollmer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORM. IT <b>Karl E. Waldron (Same as above)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sudden arrest &amp; expiration of ventricle</b> DUE TO <b>during surgery</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Industrial distention &amp; wound dehiscence</b> DUE TO <b>Recent resection of cecum &amp; Co.-colon</b> (c) <b>Carcinoma of vermiform appendix</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>0</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JOHN T. MALONEY, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/12/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodland Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Quincy, Illinois</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Malley's Funeral Home</b>				ADDRESS <b>Mt. Rainier Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 11 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>			

MEDICAL CERTIFICATION

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STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
ALBANY, N. Y.

Woodward Commission

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8358

File 6268 8-8-60

08385

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pringe Geoge Co</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>12 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ellen</b> Middle <b>Walton</b> Last <b>Walton</b>		4. DATE OF DEATH Month <b>July</b> Day <b>31</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OF HAIR <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/16/98</b>
9. AGE (In years lost birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR: Months <b>61</b> Days <b>19</b> Hours <b>60</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D. C.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Washington</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>170X</b>	
17. INFORMANT <b>George Washington</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA, BREAST, MULTIPLE ORGAN METASTASES</b> DUE TO <b>CARCINOMA OF THE BREAST</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4 MONTHS</b> DUE TO <b>4 MONTHS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2 WEEKS</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 20</b> <b>1960</b> , to <b>July 31</b> <b>1960</b> , that (I) (we) last saw the deceased alive on <b>July 31</b> <b>1960</b> , and that death occurred at <b>8:05 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. C. James Duke, M.D.</b>		22b. DATE SIGNED <b>8/1/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. C. James Duke, M.D.</b>		22d. ADDRESS <b>6807 Riverdale Road Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-5-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial</b>		23d. LOCATION (City, town, or county) (State) <b>D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Edmondson</b>		25a. REC'D BY REGISTRAR <b>909-6-5111</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25c. DATE <b>8-1-60</b>	

AUG 5 '60





8410

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY <b>P. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>				c. LENGTH OF STAY IN 1b <b>18 WASHINGTON</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL ANDREWS, WASH 25 DC</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>M/B</b> Middle <b>W</b> Last <b>WEBER</b>				4. DATE OF DEATH Month <b>July</b> Day <b>12</b> Year <b>1960</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>CAUC</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11 JULY 1960</b>		9. AGE (In years last birthday) yrs. <b>8</b> Months <b>15</b> Days <b>15</b> Hrs. <b>15</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>Charles J. Weber</b>				14. MOTHER'S MAIDEN NAME <b>Margaret M. Weber</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>HOSPITAL RECORD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory distress syndrome</b> <b>774X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Premature birth</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>8 hr 15 min</b> <b>8 hr 15 min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11 July, 1960</b> , to <b>12 July, 1960</b> , that I last saw the deceased alive on <b>12 July, 1960</b> , and that death occurred at <b>0800 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>USAF HOSPITAL ANDREWS</b> DATE SIGNED <b>12 JULY 1960</b>							
ACTUAL SIGNATURE <b>John A. Moore</b> M.D.				PHYSICIAN'S NAME (Type) <b>JOHN A. MOORE, MAJ USAF (MC)</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>7/14/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery Montgomery &amp; Pa</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F Gascho Sons Hyattsville Md</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 15 1960</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krauss</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

08387

8359

<b>1. PLACE OF DEATH</b> a. COUNTY <u>PRINCE GEORGE'S</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE'S</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGE'S GENERAL HOSPITAL</u>				e. STREET ADDRESS <u>4712 C HURON AVE</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>FLORICE</u> Middle <u>W. WEBSTER</u> Last				<b>4. DATE OF DEATH</b> Month <u>JULY</u> Day <u>29</u> Year <u>1960</u>			
<b>5. SEX</b> <u>FEMALE</u>		<b>6. COLOR OR RACE</b> <u>CAUCASIAN</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>FEB 14, 1897</u>	
<b>9. AGE</b> (In years last birthday) <u>63</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>CORRESPONDENT</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>DEPT. U.S. AGRICULTURAL</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>GREEN CO. PENN'A.</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>CHARLES T. WEBSTER</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>MADORA MCNEELY</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>UNKNOWN</u>	
<b>16. SOCIAL SECURITY NO.</b> <u>UNKNOWN</u>		<b>17. INFORMANT</b> <u>COWISON, GRAHAM, P WASH PA.</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>Insufficiency</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> (County) (State)				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21. I certify that I attended the deceased from</b> <u>1957</u> to <u>7-29</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7-27</u> , 19 <u>60</u> , and that death occurred at <u>7:10 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
<b>ACTUAL SIGNATURE</b> <u>John P. D'Angelo M.D.</u>				<b>PHYSICIAN'S NAME (Type)</b> <u>John P. D'Angelo M.D.</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>AUG 1, 1960</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>ROSEMONT CEMETERY</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>ROGERSVILLE, PENN'A.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W.W. Chambers Co. Riverdale, Md.</u>				<b>24a. REC'D BY REGISTRAR</b> DATE <u>AUG 3 '60</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

100



8360

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>39 East Hyattsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George Hospital</b>		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES	
3. NAME OF DECEASED (Type or print) <b>Norvelle W Wharton</b>		4. DATE OF DEATH Month <b>July</b> Day <b>9</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 12, 1906</b>
9. AGE (In years last birthday) <b>54</b> yrs.		10. IF UNDER 1 YEAR: Months <b>54</b> Days <b>19</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Furniture</b>	
11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Wharton</b>		14. MOTHER'S MAIDEN NAME <b>Bessie I Wharton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Address <b>Alta S. Wharton 5602 Hamilton St. Hyttv.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> DUE TO <b>Ca of Larynx &amp; Lungs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>2 yrs.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 2, 1958</b> to <b>7/9, 1960</b> that I last saw the deceased alive on <b>7/9, 1960</b> and that death occurred at <b>5:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George J. Hageage</b>		ADDRESS (Street, city or town, state) <b>3717-38th Ave</b> DATE SIGNED <b>7/9/60</b>	
PHYSICIAN'S NAME (Type) <b>George J. Hageage</b>		<b>3717-38th Ave</b> <b>Cottman City, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/12/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Prince George Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter W. Deal</b>		24a. REC'D BY REGISTRAR <b>DATE</b> <b>Jul 18 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00330

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is oriented horizontally but contains vertical text labels for various fields.

1. Name of Deceased: \_\_\_\_\_

2. Date of Death: \_\_\_\_\_

3. Place of Death: \_\_\_\_\_

4. Cause of Death: \_\_\_\_\_

5. Signature of Physician: \_\_\_\_\_

6. Signature of Registrar: \_\_\_\_\_

7. Date of Registration: \_\_\_\_\_

8. Place of Registration: \_\_\_\_\_

9. Name of Registrar: \_\_\_\_\_

10. Address of Registrar: \_\_\_\_\_

11. City: \_\_\_\_\_

12. State: \_\_\_\_\_

13. Zip: \_\_\_\_\_

14. County: \_\_\_\_\_

15. District: \_\_\_\_\_

16. Precinct: \_\_\_\_\_

17. Block: \_\_\_\_\_

18. Lot: \_\_\_\_\_

19. Sublot: \_\_\_\_\_

20. Section: \_\_\_\_\_

21. Township: \_\_\_\_\_

22. Range: \_\_\_\_\_

23. Section: \_\_\_\_\_

24. Block: \_\_\_\_\_

25. Lot: \_\_\_\_\_

26. Sublot: \_\_\_\_\_

27. Section: \_\_\_\_\_

28. Township: \_\_\_\_\_

29. Range: \_\_\_\_\_

30. Section: \_\_\_\_\_

31. Block: \_\_\_\_\_

32. Lot: \_\_\_\_\_

33. Sublot: \_\_\_\_\_

34. Section: \_\_\_\_\_

35. Township: \_\_\_\_\_

36. Range: \_\_\_\_\_

37. Section: \_\_\_\_\_

38. Block: \_\_\_\_\_

39. Lot: \_\_\_\_\_

40. Sublot: \_\_\_\_\_

41. Section: \_\_\_\_\_

42. Township: \_\_\_\_\_

43. Range: \_\_\_\_\_

44. Section: \_\_\_\_\_

45. Block: \_\_\_\_\_

46. Lot: \_\_\_\_\_

47. Sublot: \_\_\_\_\_

48. Section: \_\_\_\_\_

49. Township: \_\_\_\_\_

50. Range: \_\_\_\_\_

51. Section: \_\_\_\_\_

52. Block: \_\_\_\_\_

53. Lot: \_\_\_\_\_

54. Sublot: \_\_\_\_\_

55. Section: \_\_\_\_\_

56. Township: \_\_\_\_\_

57. Range: \_\_\_\_\_

58. Section: \_\_\_\_\_

59. Block: \_\_\_\_\_

60. Lot: \_\_\_\_\_

61. Sublot: \_\_\_\_\_

62. Section: \_\_\_\_\_

63. Township: \_\_\_\_\_

64. Range: \_\_\_\_\_

65. Section: \_\_\_\_\_

66. Block: \_\_\_\_\_

67. Lot: \_\_\_\_\_

68. Sublot: \_\_\_\_\_

69. Section: \_\_\_\_\_

70. Township: \_\_\_\_\_

71. Range: \_\_\_\_\_

72. Section: \_\_\_\_\_

73. Block: \_\_\_\_\_

74. Lot: \_\_\_\_\_

75. Sublot: \_\_\_\_\_

76. Section: \_\_\_\_\_

77. Township: \_\_\_\_\_

78. Range: \_\_\_\_\_

79. Section: \_\_\_\_\_

80. Block: \_\_\_\_\_

81. Lot: \_\_\_\_\_

82. Sublot: \_\_\_\_\_

83. Section: \_\_\_\_\_

84. Township: \_\_\_\_\_

85. Range: \_\_\_\_\_

86. Section: \_\_\_\_\_

87. Block: \_\_\_\_\_

88. Lot: \_\_\_\_\_

89. Sublot: \_\_\_\_\_

90. Section: \_\_\_\_\_

91. Township: \_\_\_\_\_

92. Range: \_\_\_\_\_

93. Section: \_\_\_\_\_

94. Block: \_\_\_\_\_

95. Lot: \_\_\_\_\_

96. Sublot: \_\_\_\_\_

97. Section: \_\_\_\_\_

98. Township: \_\_\_\_\_

99. Range: \_\_\_\_\_

100. Section: \_\_\_\_\_

101. Block: \_\_\_\_\_

102. Lot: \_\_\_\_\_

103. Sublot: \_\_\_\_\_

104. Section: \_\_\_\_\_

105. Township: \_\_\_\_\_

106. Range: \_\_\_\_\_

107. Section: \_\_\_\_\_

108. Block: \_\_\_\_\_

109. Lot: \_\_\_\_\_

110. Sublot: \_\_\_\_\_

111. Section: \_\_\_\_\_

112. Township: \_\_\_\_\_

113. Range: \_\_\_\_\_

114. Section: \_\_\_\_\_

115. Block: \_\_\_\_\_

116. Lot: \_\_\_\_\_

117. Sublot: \_\_\_\_\_

118. Section: \_\_\_\_\_

119. Township: \_\_\_\_\_

120. Range: \_\_\_\_\_

121. Section: \_\_\_\_\_

122. Block: \_\_\_\_\_

123. Lot: \_\_\_\_\_

124. Sublot: \_\_\_\_\_

125. Section: \_\_\_\_\_

126. Township: \_\_\_\_\_

127. Range: \_\_\_\_\_

128. Section: \_\_\_\_\_

129. Block: \_\_\_\_\_

130. Lot: \_\_\_\_\_

131. Sublot: \_\_\_\_\_

132. Section: \_\_\_\_\_

133. Township: \_\_\_\_\_

134. Range: \_\_\_\_\_

135. Section: \_\_\_\_\_

136. Block: \_\_\_\_\_

137. Lot: \_\_\_\_\_

138. Sublot: \_\_\_\_\_

139. Section: \_\_\_\_\_

140. Township: \_\_\_\_\_

141. Range: \_\_\_\_\_

142. Section: \_\_\_\_\_

143. Block: \_\_\_\_\_

144. Lot: \_\_\_\_\_

145. Sublot: \_\_\_\_\_

146. Section: \_\_\_\_\_

147. Township: \_\_\_\_\_

148. Range: \_\_\_\_\_

149. Section: \_\_\_\_\_

150. Block: \_\_\_\_\_

151. Lot: \_\_\_\_\_

152. Sublot: \_\_\_\_\_

153. Section: \_\_\_\_\_

154. Township: \_\_\_\_\_

155. Range: \_\_\_\_\_

156. Section: \_\_\_\_\_

157. Block: \_\_\_\_\_

158. Lot: \_\_\_\_\_

159. Sublot: \_\_\_\_\_

160. Section: \_\_\_\_\_

161. Township: \_\_\_\_\_

162. Range: \_\_\_\_\_

163. Section: \_\_\_\_\_

164. Block: \_\_\_\_\_

165. Lot: \_\_\_\_\_

166. Sublot: \_\_\_\_\_

167. Section: \_\_\_\_\_

168. Township: \_\_\_\_\_

169. Range: \_\_\_\_\_

170. Section: \_\_\_\_\_

171. Block: \_\_\_\_\_

172. Lot: \_\_\_\_\_

173. Sublot: \_\_\_\_\_

174. Section: \_\_\_\_\_

175. Township: \_\_\_\_\_

176. Range: \_\_\_\_\_

177. Section: \_\_\_\_\_

178. Block: \_\_\_\_\_

179. Lot: \_\_\_\_\_

180. Sublot: \_\_\_\_\_

181. Section: \_\_\_\_\_

182. Township: \_\_\_\_\_

183. Range: \_\_\_\_\_

184. Section: \_\_\_\_\_

185. Block: \_\_\_\_\_

186. Lot: \_\_\_\_\_

187. Sublot: \_\_\_\_\_

188. Section: \_\_\_\_\_

189. Township: \_\_\_\_\_

190. Range: \_\_\_\_\_

191. Section: \_\_\_\_\_

192. Block: \_\_\_\_\_

193. Lot: \_\_\_\_\_

194. Sublot: \_\_\_\_\_

195. Section: \_\_\_\_\_

196. Township: \_\_\_\_\_

197. Range: \_\_\_\_\_

198. Section: \_\_\_\_\_

199. Block: \_\_\_\_\_

200. Lot: \_\_\_\_\_

201. Sublot: \_\_\_\_\_

202. Section: \_\_\_\_\_

203. Township: \_\_\_\_\_

204. Range: \_\_\_\_\_

205. Section: \_\_\_\_\_

206. Block: \_\_\_\_\_

207. Lot: \_\_\_\_\_

208. Sublot: \_\_\_\_\_

209. Section: \_\_\_\_\_

210. Township: \_\_\_\_\_

211. Range: \_\_\_\_\_

212. Section: \_\_\_\_\_

213. Block: \_\_\_\_\_

214. Lot: \_\_\_\_\_

215. Sublot: \_\_\_\_\_

216. Section: \_\_\_\_\_

217. Township: \_\_\_\_\_

218. Range: \_\_\_\_\_

219. Section: \_\_\_\_\_

220. Block: \_\_\_\_\_

221. Lot: \_\_\_\_\_

222. Sublot: \_\_\_\_\_

223. Section: \_\_\_\_\_

224. Township: \_\_\_\_\_

225. Range: \_\_\_\_\_

226. Section: \_\_\_\_\_

227. Block: \_\_\_\_\_

228. Lot: \_\_\_\_\_

229. Sublot: \_\_\_\_\_

230. Section: \_\_\_\_\_

231. Township: \_\_\_\_\_

232. Range: \_\_\_\_\_

233. Section: \_\_\_\_\_

234. Block: \_\_\_\_\_

235. Lot: \_\_\_\_\_

236. Sublot: \_\_\_\_\_

237. Section: \_\_\_\_\_

238. Township: \_\_\_\_\_

239. Range: \_\_\_\_\_

240. Section: \_\_\_\_\_

241. Block: \_\_\_\_\_

242. Lot: \_\_\_\_\_

243. Sublot: \_\_\_\_\_

244. Section: \_\_\_\_\_

245. Township: \_\_\_\_\_

246. Range: \_\_\_\_\_

247. Section: \_\_\_\_\_

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908. Sublot: \_\_\_\_\_

909. Section: \_\_\_\_\_

910. Township: \_\_\_\_\_

911. Range: \_\_\_\_\_

912. Section: \_\_\_\_\_

913. Block: \_\_\_\_\_

914. Lot: \_\_\_\_\_

915. Sublot: \_\_\_\_\_

916. Section: \_\_\_\_\_

917. Township: \_\_\_\_\_

918. Range: \_\_\_\_\_

919. Section: \_\_\_\_\_

920. Block: \_\_\_\_\_

921. Lot: \_\_\_\_\_

922. Sublot: \_\_\_\_\_

923. Section: \_\_\_\_\_

924. Township: \_\_\_\_\_

925. Range: \_\_\_\_\_

926. Section: \_\_\_\_\_

927. Block: \_\_\_\_\_

928. Lot: \_\_\_\_\_

929. Sublot: \_\_\_\_\_

930. Section: \_\_\_\_\_

931. Township: \_\_\_\_\_

932. Range: \_\_\_\_\_

933. Section: \_\_\_\_\_

934. Block: \_\_\_\_\_

935. Lot: \_\_\_\_\_

936. Sublot: \_\_\_\_\_

937. Section: \_\_\_\_\_

938. Township: \_\_\_\_\_

939. Range: \_\_\_\_\_

940. Section: \_\_\_\_\_

941. Block: \_\_\_\_\_

942. Lot: \_\_\_\_\_

943. Sublot: \_\_\_\_\_

944. Section: \_\_\_\_\_

945. Township: \_\_\_\_\_

946. Range: \_\_\_\_\_

947. Section: \_\_\_\_\_

948. Block: \_\_\_\_\_

949. Lot: \_\_\_\_\_

950. Sublot: \_\_\_\_\_

951. Section: \_\_\_\_\_

952. Township: \_\_\_\_\_

953. Range: \_\_\_\_\_

954. Section: \_\_\_\_\_

955. Block: \_\_\_\_\_

956. Lot: \_\_\_\_\_

957. Sublot: \_\_\_\_\_

958. Section: \_\_\_\_\_

959. Township: \_\_\_\_\_

960. Range: \_\_\_\_\_

961. Section: \_\_\_\_\_

962. Block: \_\_\_\_\_

963. Lot: \_\_\_\_\_

964. Sublot: \_\_\_\_\_

965. Section: \_\_\_\_\_

966. Township: \_\_\_\_\_

967. Range: \_\_\_\_\_

968. Section: \_\_\_\_\_

969. Block: \_\_\_\_\_

970. Lot: \_\_\_\_\_

971. Sublot: \_\_\_\_\_

972. Section: \_\_\_\_\_

973. Township: \_\_\_\_\_

974. Range: \_\_\_\_\_

975. Section: \_\_\_\_\_

976. Block: \_\_\_\_\_

977. Lot: \_\_\_\_\_

978. Sublot: \_\_\_\_\_

979. Section: \_\_\_\_\_

980. Township: \_\_\_\_\_

981. Range: \_\_\_\_\_

982. Section: \_\_\_\_\_

983. Block: \_\_\_\_\_

984. Lot: \_\_\_\_\_

985. Sublot: \_\_\_\_\_

986. Section: \_\_\_\_\_

987. Township: \_\_\_\_\_

988. Range: \_\_\_\_\_

989. Section: \_\_\_\_\_

990. Block: \_\_\_\_\_

991. Lot: \_\_\_\_\_

992. Sublot: \_\_\_\_\_

993. Section: \_\_\_\_\_

994. Township: \_\_\_\_\_

995. Range: \_\_\_\_\_

996. Section: \_\_\_\_\_

997. Block: \_\_\_\_\_

998. Lot: \_\_\_\_\_

999. Sublot: \_\_\_\_\_

1000. Section: \_\_\_\_\_

902

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 9, 14 Film G267 7-26-60 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

08389

8411

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>INDIANA</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CULVER CITY</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSP ANDREWS, ANDREWS AFB, WASH</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>L</b> Last <b>WHITE</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>18</b> Year <b>1960</b>		5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAUCASIAN</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>25 OCTOBER 1888</b>		9. AGE (In years lost birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>BOYD SMITH</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>		Address <b>MRS MELVYN ESTEY SAME AS #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UNCONTROLLABLE SHOCK</b> DUE TO <b>HEAD INJURY</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HEAD INJURY</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>10 MIN</b> <b>10 MIN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>CAR ACCIDENT</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>Jul 18, 1960</b> p. m. <b>1235</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>STREET</b>		20f. (City or town) <b>BRANDYWINE</b> (County) <b>PRINCE GEORGES</b> (State) <b>MD</b>	
21. I certify that I attended the deceased from <b>18 JULY</b> , 19 <b>60</b> , to <b>18 JULY</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>18 JULY</b> , 19 <b>60</b> , and that death occurred at <b>2:45 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert J Mc Cann</b>		M.D. <b>USAF HOSPITAL ANDREWS</b>		ADDRESS (Street, city or town, state) <b>ANDREWS AIR FORCE BASE, WASHINGTON 25, DC</b>		DATE SIGNED <b>18 JULY 60</b>	
PHYSICIAN'S NAME (Type) <b>ROBERT J MC CANN, MAJ USAF (MC)</b>		22a. LOCATION (City, town, or county) (State) <b>HANOVER Township, PA.</b>					
22b. DATE THEREOF <b>July 21, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>OAKLAWN Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>HANOVER Township, PA.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Gawlers Sons</b>		ADDRESS <b>1736 PA AVE. N.W. WASHINGTON, D.C.</b>		24a. REC'D BY REGISTRAR <b>JUL 20 60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Adams</b>	

08389

CERTIFICATE OF DEATH

8411



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
8412										
CERTIFICATE OF DEATH										
Reg. Dist. No. 09534										
1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton			c. LENGTH OF STAY IN 1b 24 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Southern Maryland Hospital Center					d. STREET ADDRESS Po Box 12.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Agnes B. Wilkerson					4. DATE OF DEATH July 31 1960					
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 27 1913		9. AGE (In years last birthday) 47 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Bob Shorter					14. MOTHER'S MAIDEN NAME LULLIA WELSH					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. No. None		INFORMANT Benjamin Wilkerson (Husb)			Address Brandywine md		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 152.3 Uremia DUE TO (b) generalized carcinomatosis DUE TO (c) carcinoma of sigmoid colon. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								INTERVAL BETWEEN ONSET AND DEATH 2-3 days 6-8 months 2-3 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 10, 1960, to July 31, 1960, that I last saw the deceased alive on July 31, 1960, and that death occurred at 1:27 P.M. from the causes and on the date stated above.										
ACTUAL SIGNATURE David N. Robb					ADDRESS (Street, city or town, state) Southern Maryland Hospital Center					DATE SIGNED
PHYSICIAN'S NAME (Type) DAVID N. ROBB					Clinton Md.					July 31 1960
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF Aug 4, 1960		22c. NAME OF CEMETERY OR CREMATORY Arlington National			22d. LOCATION (City, town, or county) (State) Arlington, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE Hunt & Funeral Home, Waldorf, Md					ADDRESS		24a. REC'D BY REGISTRAR DATE AUG 10 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



2024

Three to five hundred years old  
Buried in 1950 Washington National  
Washington, Virginia

may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

8361

08390

1. PLACE OF DEATH a. COUNTY <i>P. Georges</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md.</i> b. COUNTY <i>P. Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesedley</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>23 District Heights</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>P. Georges' General</i>				d. STREET ADDRESS <i>17401 Halleck St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Albert</i> Middle <i>E.</i> Last <i>Williams</i>		4. DATE OF DEATH		Month <i>7</i> Day <i>23</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-6-1895</i>		9. AGE (In years last birthday) <i>65</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired attendant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Gas Station</i>		11. BIRTHPLACE (State or foreign country) <i>England</i>		12. CITIZEN OF WHAT COUNTRY? <i>England</i>	
13. FATHER'S NAME <i>Charles Williams</i>				14. MOTHER'S MAIDEN NAME <i>unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>578-14-6618</i>		17. INFORMANT <i>Saura M Williams</i> Address <i>7401 Halleck St</i>		<i>Lowest Heights Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <i>443X</i> IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO (b) <i>uremia</i> DUE TO (c) <i>Hypertensive Cardiovascular Disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i> <i>3 mos.</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>7/22</i> <i>1960</i> , to <i>7/23</i> <i>1960</i> , that (I) (we) last saw the deceased alive on <i>7/23</i> <i>1960</i> , and that death occurred at <i>8:15</i> PM, from the causes and on the date stated above.							
22a. SIGNATURE <i>Norman Donat Comeran</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>7/23/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Norman Donat Comeran</i>				22d. ADDRESS <i>3503 Pennyst Mt Pavier Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7-27-60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		23d. LOCATION (City, town, or county) (State) <i>Seutland Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Frank Seiers Sons Co</i>				ADDRESS <i>3605-14 St NW</i>		25a. REC'D BY REGISTRAR DATE <i>JUL 26 '60</i>	
						25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kray</i>	

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CERTIFICATE OF DEATH

1981

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## CERTIFICATE OF DEATH

08391

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>PR. GEORGE'S MARYLAND</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>D-C</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Clinton</i>		c. LENGTH OF STAY IN 1b <i>42mo - 7 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brandywine Bldg 220</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Southern Md. Hosp. Center</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>FRANCES DOROTHY WILSON</i>				4. DATE OF DEATH Month Day Year <i>JULY 28 1960</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-21-1908</i>		9. AGE (In years lost birthday) <i>52 yrs.</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>		11. BIRTHPLACE (State or foreign country) <i>WASH. D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Harry Madden</i>				14. MOTHER'S MAIDEN NAME <i>Alice Madden</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		INFORMANT <i>GARNER G. WILSON</i>		Address <i>Bal 220 BRANDYWINE MD.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cardiovascular collapse</i> DUE TO (c) <i>Carcinomatosis, generalized</i> INTERVAL BETWEEN ONSET AND DEATH <i>3-4 days</i> <i>4 yrs.</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Carcinoma of Uterus removed by surgery</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3/21</i> , 19 <i>60</i> to <i>7/28</i> , 19 <i>60</i> that I last saw the deceased alive on <i>7/28</i> , 19 <i>60</i> , and that death occurred at <i>2:10 P.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Alfred R. Lapin</i> M.D.				ADDRESS (Street, city or town, state) <i>Woodyard Rd Clinton, Md</i>			
PHYSICIAN'S NAME (Type) <i>CLINTON, MD.</i>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>8-1-60</i>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <i>mt Olivet</i>		22d. LOCATION (City, town, or county) (State) <i>Washington D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry S. Washburn</i> ADDRESS <i>4925 Neane Ave NE.</i>				24a. REC'D BY REGISTRAR DATE <i>AUG 1 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

10830

CERTIFICATE OF DEATH

1911

NO. 10830

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**CERTIFICATE OF DEATH**

Reg. Dist. No.

08392

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box 2300 Church Rd.</b>				e. STREET ADDRESS <b>Upper Marlboro,</b>			
3. NAME OF DECEASED (Type or print) <b>HARRY</b> First <b>ROBERT</b> Middle <b>Windsor</b> Last				4. DATE OF DEATH <b>July</b> Month <b>26</b> Day <b>1960</b> Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-23-1907</b>	
9. AGE (In year last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Charles Windsor</b>				14. MOTHER'S MAIDEN NAME <b>Mary Robinson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>58 28 6927</b>		17. INFORMANT <b>Mary Windsor Box 2300 Church Rd., Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Cardiac Decompensation</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Coronary Sclerosis.</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH. <b>2 yrs.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 1955</b> to <b>26 July 1960</b> , that I last saw the deceased alive on <b>22 July 1960</b> , and that death occurred at <b>3:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>26-7-60</b>							
ACTUAL SIGNATURE <b>J. B. James</b> M.D.				PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-29-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel</b>		22d. LOCATION (City, town, or county) (State) <b>Upper Marlboro, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Myrtle K. Gallun</b> ADDRESS <b>4339 Hunt Pl., N.E., D.C.</b>				24a. REC'D BY REGISTRAR <b>JUL 29 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. James</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
8362 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08393

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Naylor</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>RFD Box 3640</b>			
3. NAME OF DECEASED (Type or print) <b>Thomas Darnall Windsor</b>				4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 7, 1885</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		10. UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>60</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Robert Windsor</b>				14. MOTHER'S MAIDEN NAME <b>Mary Boswell</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>577-22-2392</b>			
17. INFORMANT <b>Nellie M. Cooksey</b>				Address <b>RFD Box 3640 Naylor Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b> (c) <b>Cardiovascular renal disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James I. Boyd</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>7/28/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>7/30/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel</b>	
23. FUNERAL DIRECTOR <b>Huntt Funeral Home</b>				ADDRESS <b>Waldorf, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 2 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Haus</b>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9-59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

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08394

<b>1. PLACE OF DEATH</b> o. COUNTY <b>Prince Georges</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchellsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>Rt. 1 Box 3</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Baby Boy Wright</b>				<b>4. DATE OF DEATH</b> Month <b>12</b> Day <b>July</b> Year <b>1960</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Black</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11 July 1960</b>			
9. AGE (In years lost birthday) yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
13. FATHER'S NAME <b>Whitfield Franklin</b>				14. MOTHER'S MAIDEN NAME <b>Henreitta Wright</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mother</b>		Address <b>Same</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>762.5</b> IMMEDIATE CAUSE (a) <b>prematurity</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>atherosclerosis</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <b>July 11 1960</b>				20g. (County) <b>Prince Georges</b>		20h. (State) <b>MARYLAND</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>July 11 1960</b> to <b>July 12 1960</b> , that (I) (we) last saw the deceased alive on <b>July 12 1960</b> , and that death occurred at <b>3:00AM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Thomas A. Christensen</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>July 12</b>			
22c. PHYSICIAN'S NAME (Type) <b>Thomas A. Christensen</b>				22d. ADDRESS <b>6905 Baltimore Ave. College Park, M.D.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>8-4-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prince George's Gen. Hosp. Cheverly, MARYLAND</b>		23d. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr.</b> Administrator				25a. REC'D BY REGISTRAR DATE <b>AUG 8 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Hanks</b>			

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